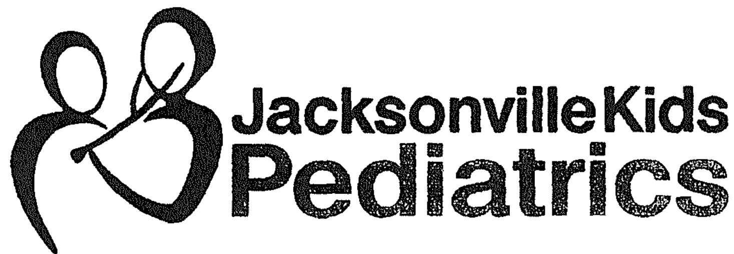

AUTHORIZATION FOR TREATMENT

Date:____________________

Patient Name:__________________________________ **Date of Birth:**________________

Patient Name:__________________________________ **Date of Birth:**________________

Patient Name:__________________________________ **Date of Birth:**________________

Patient Name:__________________________________ **Date of Birth:**________________

Patient Name:__________________________________ **Date of Birth:**________________

Patient Name:__________________________________ **Date of Birth:**________________

In the event that I am unable to bring my child(ren) to the office, I consent for the following persons to authorize medical care that is recommended by any of the Jacksonville Kids Pediatrics physicians.

Name:____ **Relationship:**________________

Name:____ **Relationship:**________________

Name:____ **Relationship:**________________

Parent/Guardian Signature:____