Lake Norman Pediatrics

Consent for Treatment

_______________________________________ _____________
Child's Legal Name-Last, First, Middle) (Date of Birth)

_______________________________________ _____________
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_______________________________________ _____________
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_______________________________________ _____________
Child's Legal Name-Last, First, Middle) (Date of Birth)

I authorize the medical personnel of Lake Norman Pediatrics to treat my child if illness or injury occurs during my absence.

Signature of Parent/Legal Guardian____Date_________

I give my consent for Lake Norman Pediatrics to administer Well Child immunizations or injectable medications.

Signature of Parent/Legal Guardian____Date_________

I give the following people authority to bring my child in for Sick or Well Child appointments during my absence, including authorization to administer Well Child immunizations or injectable medications.

1.______________________________________ ____________________ ___________________
(Name) (Telephone Number) (Relationship)

2.______________________________________ ____________________ ___________________
(Name) (Telephone Number) (Relationship)

3.______________________________________ ____________________ ___________________
(Name) (Telephone Number) (Relationship)

Signature of Parent/Legal Guardian____Date_________

This authorization for treatment is valid until revoked in writing by Parent /Legal Guardian.

____ ___________________________
(Witness Signature) (Date)