## Permission to Treat

I (we) _____ authorize Wadsworth Pediatrics and its personnel to
*Print name(s) of legal guardian(s)*

Deliver medical services to my child(ren):

_____
Child's name and date of birth

_____
Child's name and date of birth

_____
Child's name and date of birth

_____
Child's name and date of birth

_____
Child's name and date of birth

_____
Child's name and date of birth

I (we) authorize the following people to bring my child(ren) in for treatment and/or seek medical advice via phone regarding them:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____/_____/_____
Signature of legal guardian date

_____
Relationship to patient

William F. Oehlenschlager, M.D., Ph.D. Julie A. Reynolds, M.D.
Kimberly A. Blair, M.D. Shelli I. Reed, C.P.N.P.

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