**BAYSHORE PEDIATRICS @ SPACE CENTER, P.A.**
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# MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

PLEASE BE AWARE THAT BY LAW WE ARE UNABLE TO TREAT A MINOR, UNLESS YOU ARE THE PARENT OR LEGAL GUARDIAN WITH PROOF OF GUARDIANSHIP. IF YOU ARE NEITHER THE PARENT NOR LEGAL GUARDIAN WE MUST HAVE AND AUTHORIZATION LETTER TO TREAT THE CHILD FROM THE PARENTS OR LEGAL GUARDIAN.

I (WE), _____, HEREBY CERTIFY TO BE THE PARENT(S) OR LEGAL GUARDIAN(S) OF:_____.
(NAME OF PATIENT AND DATE OF BIRTH)

If due to extenuating circumstances you are unable to bring your child to our office, you authorize the named individuals below to consent for medical treatments (and/or other medical procedures) for the above named child, which may be required during your absence. This "MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM" gives authority to a designated adult to arrange for medical care for your child in the case of your absence. Designated adults must be at least 18 years of age. You have the right to add/remove any of the named individuals by coming into the office and updating in person. If in case and individual not listed below presents to the office with your child seeking treatment, you authorize us to contact you, the listed parent(s)/guardian(s) above for consent. All authorizations will be documented.

| NAME | RELATIONSHIP TO CHILD |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |
| 4._____ | _____ |
| 5._____ | _____ |
| 6._____ | _____ |

_____ _____
SIGNATURE DATE