CHAPERONE MEDICAL CONSENT (FOR A MINOR)

I, ______________________ the parent or legal guardian of ___________________________, born on (DOB) ____________do hereby consent and allow (name) ______________________ DOB______________ residing at ____
____

to bring my child to Avala Pediatrics and receive any type of medical care needed for my child including immunizations, and any other care recommended or deemed as necessary for the welfare of my child. I understand the above-named party is responsible for informing me of all information related to services received.

This authorization is effective from (Date)__________________ and expires on (Date)_______________________

_____________________________________ ___________ _____________________

Signature of Parent or Legal Guardian **Date** **Print Name**

_____________________________________ ___________ _____________________

Signature of Witness **Date** **Print Name**

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information is optional but will assist in treatment if it can be furnished with the consent but is not required.

Father's Telephone: _____________________ Mother's Telephone: _____________________

Allergies to drugs or foods: ____

Special Medications, or Pertinent Information: ______________________________________

____

Insurance: ________________________________ Policy # ________________

Avala Pediatrics