CONSENT TO TREAT MINOR

I hereby give consent to Point Pediatrics to deliver medical treatment to my child/children listed below.

I understand that this authorization is given in advance of any specific diagnosis or treatment required.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

_____ _____/_____/_____

Patient/Responsible Party Signature Date

CHILD's NAME: _____ DOB: _____

CHILD's NAME: _____ DOB: _____

CHILD's NAME: _____ DOB: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

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Point PEDIATRICS