IVY CHILDREN'S CLINIC

CONSENT FOR TREATMENT AUTHORIZATION

Child's Name: _____ Date of Birth: _____

Parent or Legal Guardian's Printed Name: _____

Parent or Legal Guardian's Printed Name: _____

I hereby authorize the following person(s) to seek medical care and make decisions in relation to recommendations from Ivy Children's Clinic and/or its employees for my child/ward in my absence:

_____ _____
Printed Name Relationship

_____ _____
Printed Name Relationship

_____ _____
Printed Name Relationship

_____ _____
Printed Name Relationship

For the following period:

• _____ Through _____

• Until such time as this authorization is revoked in writing.

_____ _____ _____
Signature Relationship Date