WESTSIDE PEDIATRIC CLINIC

Authorization to Treat in the Absence of Parent of Guardian

I authorize the following person(s) to attend visit with my child and to consent to medical treatment by any provider at Westside Pediatric Clinic, P.C.

1. _____
2. _____
3. _____

The authorization is for my child/children

1. _____
2. _____
3. _____
4. _____

_____

Signature **Date**