



Community

Physicians of Indiana

Parent/Legal Guardian Authorization for Medical Care for Child

Name of Child: _____

Date of Birth: _____

I (We) _____ grant _____
Parent/Legal Guardian Person Accompanying Child

permission to seek medical care and consent to treatment as deemed necessary to the above named dependant in my absence. The care will be given at the office of

Name of Physician and/or Practice

Parent/Legal Guardian Signature: _____

Date: _____