Woburn Pediatric Associates
7 Alfred Street · Baldwin Park II
Woburn, MA 01801
781-933-6236

North Andover Pediatric Associates
800 Turnpike Street · Jefferson Office Park
North Andover, MA 01845
978-557-5712

Authorization to Consent to Medical Care for a Minor Child

Date _____
(Valid for one year from provided date, unless otherwise specified)

I/We _____
(Name(s) of Parent(s)/Guardian(s))

_____
(Address & Phone Number)

do hereby state that I/we are the parent(s)/guardian(s) having legal custody of

_____ _____
(Child's name & Birthdate) (Child's name & Birthdate)

_____ _____
(Medical history, allergies, medications) (Medical history, allergies, medications)

and authorize

_____
(Adult into whose care minor(s) is entrusted & their relationship to child)

_____
(Entrusted adult's address, home, & cell numbers)

to consent to all necessary & appropriate medical care, including but not limited to **diagnostic examinations, immunizations, anesthetic, & hospital care** to be rendered to the minor at a recognized medical facility under the general or special supervision of a licensed physician.

I understand that if an injury/illness is determined to be life threatening, my provider will make every effort to contact me. If I am unreachable, the above entrusted adult may consent to emergency care for my child.

By my signature, I acknowledge that I have read & understand this consent to authorize medical care to my minor child.

_____
(Signature of Parent/Guardian)

☐ I give my permission to review demographic & insurance information.

☐ I <u>do not</u> give my permission to review demographic & insurance information.