Arundel Pediatrics Parental Authorization Consent to Treat

This form allows a parent or legal guardian to authorize another adult to seek and consent to medical care for their child(ren) at Arundel Pediatrics for a specified date of service.

Child's Information

• Full Name: _____

• Date of Birth: _____

• Allergies or Medical Conditions: _____

Authorized Adult Information

• Full Name: _____

• Relationship to Child: _____

• Phone Number: _____

Consent Details

I, the undersigned, am the parent or legal guardian of the above-named child. I hereby authorize the above-named individual to bring my child to Arundel Pediatrics for medical evaluation and treatment on the following date:

• Date of Service (valid only for this date): _____

This includes, but is not limited to: physical examinations, vaccinations, diagnostic testing, and any medically necessary treatment as deemed appropriate by the attending provider.

Parent/Guardian Information

• Name: _____

• Phone Number: _____

• Email (optional): _____

Signature and Acknowledgment

By signing below, I confirm that I am the legal guardian of the minor child and have the authority to grant this consent.

Signature of Parent/Guardian: _____

Date: _____

Note: A copy of the parent/guardian's photo ID may be required with this form. This form is only valid for the date of service listed above.