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Wheaton Pediatrics, Ltd

AUTHORIZATION FOR TREATMENT OF A MINOR CHILD
IN ABSENCE OF PARENT/GUARDIAN

PATIENT NAME (printed)

DATE OF BIRTH _____

As a parent and/or guardian, I do herewith authorize the treatment given by the staff of Wheaton Pediatrics to the above named minor, by an adult other than myself. I also authorize care appropriate to the type of visit my child is being seen for, which may include vaccines and/or other tests unless I specifically state exceptions either in writing or over the telephone. The following adult caretaker/s has/have my permission to authorize treatment for my child:

(Print name/s)

(Relationship)

Contact Numbers (Please include name):

Mother:

Father:

Other guardian: _____

SIGNATURE (parent/guardian):

WITNESS:

DATE: _____

DATE: _____

This consent is for one year unless otherwise stipulated.