

Friendship Pediatrics, P.A.

The Elizabeth Arcade 4601 North Park Avenue, Chevy Chase, MD 20815

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AUTHORIZATION TO CONSENT TO MEDICAL CARE OF A MINOR WHEN LEGAL GUARDIAN or PARENT(S) IS UNABLE TO BRING PATIENT.

I, _____, parent/legal guardian of the child(ren) listed below do hereby give my authorization and consent for the below named authorized person(s) to consent to the medical evaluation of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the legal guardian or parent(s) to bring patient for any medical evaluation deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have the authority to consent for all medical care and treatment of said child(ren):

Signature: _____ Relationship to Child(ren) _____ Date: _____

Child(ren):

| | |
|---------------|---------------|
| _____ Name | _____ Name |
| _____ Name | _____ Name |
| _____ Name | _____ Name |

Person(s) who are authorized to bring child(ren) for medical evaluation: (example: name of friend, grandparent, aunt, neighbor, babysitter, etc.)

| | |
|---------------|-------------------------------------|
| _____ Name | _____ Relationship to Child(ren) |
| _____ Name | _____ Relationship to Child(ren) |
| _____ Name | _____ Relationship to Child(ren) |
| _____ Name | _____ Relationship to Child(ren) |

If there is any change in the list, please send a written authorization to add any other person.