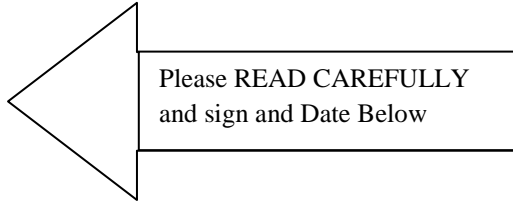




PARENT/GUARDIAN CONSENT

PARENT/GUARDIAN CONSENT



I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY PEDIATRIC ASSOCIATES OF WATERTOWN, PC OF ANY AND ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AND TO PROVIDE THE OFFICE WITH INFORMATION IF THERE ARE ANY CUSTODY RESTRICTIONS INVOLVING MY CHILD.

_____ LAST NAME OF PATIENT	_____ FIRST	_____ MIDDLE	_____ DATE OF BIRTH
_____ SOCIAL SECURITY NUMBER		_____ COURT ORDER ON FILE	
_____ MAILING ADDRESS		_____ CITY	_____ STATE
			_____ ZIP

THE PERSONS LISTED ARE THE ONLY ONES WHO MAY BE ALLOWED TO SEEK MEDICAL CARE AND/OR TREATMENT FOR MY CHILD AT PEDIATRIC ASSOCIATES OF WATERTOWN. I ALSO UNDERSTAND A PHOTO ID OF THE INDIVIDUALS WILL BE REQUIRED AT EACH VISIT AND A COPY WILL BE MADE AND PLACED IN MY CHILD'S CHART. PLEASE NOTE: ANYONE YOU ARE GRANTING PERMISSION TO MUST BE OVER THE AGE OF 18.

_____ FATHER'S NAME	_____ PREFERRED PHONE (CELL/HOME)	_____ MOTHER'S NAME	_____ PREFERRED PHONE (CELL/HOME)
_____ CHILD LIVES WITH	_____ ADDRESS	_____ RELATIONSHIP TO CHILD	

OTHER PERSONS THAT YOU CONSENT TO BRING YOUR CHILD/CHILDREN IN (MUST BE 18 YEARS OF AGE OR OLDER):

_____ OTHER (NAME)	_____ PREFERRED PHONE (CELL/HOME)	_____ RELATIONSHIP TO CHILD
_____ OTHER (NAME)	_____ PREFERRED PHONE (CELL/HOME)	_____ RELATIONSHIP TO CHILD
_____ OTHER (NAME)	_____ PREFERRED PHONE (CELL/HOME)	_____ RELATIONSHIP TO CHILD
_____ OTHER (NAME)	_____ PREFERRED PHONE (CELL/HOME)	_____ RELATIONSHIP TO CHILD

IN CASE OF AN INCIDENT WHERE I AM NOT ABLE TO BRING MY CHILD FOR HIS/HER APPOINTMENT, OR IF EMERGENCY TREATMENT IS REQUIRED, I UNDERSTAND THAT ONE OF THE PERSONS LISTED ABOVE ON THIS FORM WILL BE ALLOWED TO ARRANGE AND SEEK TREATMENT FOR MY CHILD.

BY SIGNING BELOW, I AM AWARE THAT IT IS SOLELY MY RESPONSIBILITY TO NOTIFY PEDIATRIC ASSOCIATES OF WATERTOWN, PC OF ANY/ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AS WELL AS ALL FINANCIAL RESPONSIBILITIES AND TO PROVIDE THE OFFICE WITH ANY AND ALL CUSTODY RESTRICTIONS INVOLVING MY CHILD.

PRINT PARENT/GUARDIAN NAME

PARENT/GUARDIAN SIGNATURE

RELATIONSHIP TO PATIENT

DATE