

ADVANCED PEDIATRICS

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Winter Garden, FL 34787
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AUTHORIZATION FOR MEDICAL CARE

I (WE) _____ authorize
PRINT NAME OF LEGAL GUARDIAN(S)

Advanced Pediatrics and it's personnel to deliver medical services to my
child _____
PRINT CHILD'S NAME AND DATE OF BIRTH

I (WE) authorize the following people to bring my child in for treatment:
(This form must be filled out in order for anyone other than parents listed
on patient information form to bring in your child.)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

x _____
SIGNATURE OF LEGAL GUARDIAN DATE

Relationship to patient: _____

WITNESS (PRINT/SIGN) DATE