



Physicians to Children, Inc.

21 Highland Avenue, Suite 100 • Roanoke, VA 24013

Telephone (540) 344.9213 • Facsimile (540) 345.7559

## PARENTAL CONSENT FOR MEDICAL TREATMENT

Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

In my absence, I designate the following person(s) to make any medical or surgical decisions or to participate in the treatment of my child. Information about my child may be disclosed to the following person(s) to the extent of that person's involvement with my child's care or payment for care:

1. \_\_\_\_\_  
Name Relationship
2. \_\_\_\_\_  
Name Relationship
3. \_\_\_\_\_  
Name Relationship
4. \_\_\_\_\_  
Name Relationship

I furthermore authorize the medical staff at Physicians to Children, Inc. to carry out any medical procedures and treatments that are deemed appropriate.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
\*Date

\*This consent will stay in effect from the date signed until the parent/guardian revokes the consent in writing.