List Name and Date of Birth of every child in your household

Name _____ **DOB** _____

Name: _____**DOB** _____

Authorization for Caregivers Other Than Parent or Guardian

The people listed below are designated as our agent to give consent (verbal or written) to surgical or medical treatment by any licensed physician or provider at Young Pediatrics for my minor child, and to receive relevant protected health information. Such consent may include but is not limited to, administration of necessary anesthetics, medical treatment, test, injections, immunizations or drugs and the performing of whatever procedures may be deemed necessary or advisable.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending physician, in the exercise of their best judgement, may deem advisable. This authorization shall remain effective unless revoked in writing by the undersigned.

Caregiver _____

Relationship to Patient_____

Caregiver _____

Relationship to Patient_____

Caregiver _____

Relationship to Patient_____