Beacon Pediatrics
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Rehoboth Beach, Delaware 19971
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www.BeaconPediatrics.net

Parental Consent for Medical Treatment

Child (ren) Name: _____

Home Address: _____

Home Phone: _____

Parent/Guardian Name: _____

** Below, list anyone (OTHER THEN PARENTS/GUARDIANS) who have your consent to bring child(ren) to any appointments: (list more on back if needed) The people listed NEED to have a picture ID and copy of insurance card with them when bringing your child to any appointments for security reasons.

1. Name: _____ Contact Number: _____

   Relation to child: _____

2. Name: _____ Contact Number: _____

   Relation to child: _____

3. Name: _____ Contact Number: _____

   Relation to child: _____

The above named caregiver(s) shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures for the above named child, which may be required during my absence.

This consent serves as permission for treatment by **Beacon Pediatrics, LLC** and its providers/staff. Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence. This authorization shall be effective until: (circle one)

A) _____ (Date)

B) Unless revoked by me in writing

_____ _____

Signature of Parent/Guardian Date