MANSFIELD PEDIATRICS

1825 Cannon Drive
MANSFIELD, TEXAS 76063
PHONE (817) 453-7770 / FAX (817) 453-7703

Non-Parental Authorization for Consent to Medical/ Surgical Care And Treatment

I, _____, parent/legal guardian of:

Child(ren):

_____ _____
NAME DOB

_____ _____
NAME DOB

_____ _____
NAME DOB

_____ _____
NAME DOB

Do hereby give my authorization and consent my child (named above) to be seen by Dr. Kerstin Archer, Dr. Melody A. Burton and Dr. Janet Kinney consent to the medical/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren). This is also permission to bring my child(ren) for well checks and all necessary immunizations that are routinely given at the well visit.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and treatment of said child(ren):

_____ _____ _____
Signature Relationship to child(ren) Date

Authorized Person(s):

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)