Pediatric Health Care Alliance, P.A.
Your Child's Medical Home™

Permission to Treat

I (We) _____authorize Pediatric Health Care Alliance, PA
print name(s) of legal guardian(s)

and its personnel to deliver medical services to my child(ren), listed below.

(please print)

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

I (We) authorize the following people to bring my child(ren) in for treatment, and/or to contact in case of an emergency:

Name: _____ Phone: (___) _____ Relationship: _____

Name: _____ Phone: (___) _____ Relationship: _____

Name: _____ Phone: (___) _____ Relationship: _____

Name: _____ Phone: (___) _____ Relationship: _____

_____ _____
Signature(s) of Legal Guardian(s) ***Date***

(_____) _____ _____
Primary Phone ***Relationship to patient***