Consent for Treatment by Designated Guardian

South East Bay Pediatric Medical Group
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This form allows parent(s) to designate another adult (for example, a grandparent or other relative) to bring their child in if parent(s) are unable to be present at the appointment.

Child's Name: _____

Child's Date or Birth: _____

Name of Adult Designee: _____

Relationship to Patient: _____

The above named person (designee: an adult into whose care for the minor patient has been temporarily entrusted) has my permission to bring my son and/or daughter to their scheduled appointment. I authorize the physicians of South East Bay Pediatric Medical Group, Inc. to perform on my child any necessary or routine medical or surgical treatments, including examination, injections, immunizations, and/or diagnostic procedures, including radiologic studies and/or laboratory analysis. I understand that in unusual circumstances efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of a minor is rescinded.

Parent Signature: _____ Date: _____

Parent Name: _____

○ mother ○ father

Parent Signature: _____ Date: _____

Parent Name: _____

○ mother ○ father