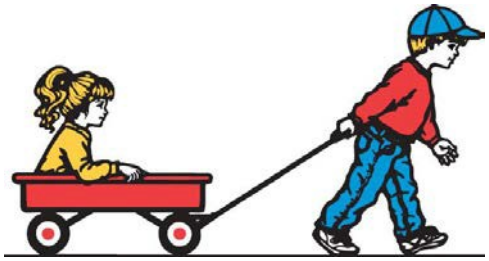

Pediatric Associates, PC

ROBERT M. LICATA, M.D., F.A.A.P. MARYGRACE ANI, M.D., F.A.A.P. GAIL PIKHOLZ, M.D., F.A.A.P.

Medical Treatment Authorization for a Minor

I, the undersigned parent/guardian of

_____(child's name)/_____(DOB) hereby grant Pediatric Associates, PC authority to provide medical treatment in my absence.

Pediatric Associates, PC recommends a parent/guardian be present for wellness exams, as immunizations may be needed. IMMUNIZATIONS WILL NOT BE ADMINISTERED WITHOUT A PARENT/GUARDIAN PRESENT.

This grant of temporary authority shall begin on_____(date) and shall remain effective until terminated by the undersigned.

In case of emergency, the care provider shall contact the following person(s) in the order listed below:

Name_____Relationship_____
Preferred Phone Number_____
Alternate Phone Number_____

Name_____Relationship_____
Preferred Phone Number_____
Alternate Phone Number_____

_____ _____

Parent/Guardian Signature Parent/Guardian Signature

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