Date ____ Child ____________________________________

AUTHORIZATION TO PROVIDE MEDICAL CARE

TO ANY HOSPITAL OR MEDICAL PROVIDER:
This document constitutes my authorization and consent for you to provide any and all medical and nursing care which you deem necessary or appropriate and in the best interest of my child:

Child's Full Name: ____
Date of Birth(Month/Day/Year): ____________________/ _____________________/ _______________

I represent to you that I have legal authority to authorize and to consent to such medical care. I further authorize the bearer of this document to execute on my behalf any and all Consent to Treatment forms, including informed consent forms for invasive procedures, which you may require as a condition of treatment.

This authorization is effective this ______________day of _____________________________ ,20_____
and shall remain in effect until I provide you with written notice of revocation.

My child's personal pediatric group is: **Parkside Pediatrics**
Physician's Name: ___________________________________
Address: 525 Verdae Blvd, Suite 200, Greenville, SC 29607
Phone: 864.272.0388

My child's insurance information is:
Insurer/HMO/PPO:________________________________Policy #:________________Group #:__________

Name of Insured:____

My child's **ALLERGIES** are:____

My child's **SIGNIFICANT MEDICAL CONDITIONS** and\or **RECENT INJURIES** are: (use back of form if necessary)

____

Date of my child's last tetanus
shot:____

A copy of this Authorization shall have the same force and effect as the original.

Signature: ____

Print Name: _____________________________ Relationship to child:________________________________

Address: ____

City,State,Zip: ____

Home Phone: (________)________________________ Cell Phone: (______) __________________________

Emergency contact other than parent:

Name:____Phone:(_____)_______________________

Relationship to child: ____________________________________