RDV SPORTSPLEX

Pediatrics

Authorization for Medical Treatment

I hereby consent to examinations, treatments and procedures (including emergency treatments) which may be deemed necessary by our physicians, their associates or staff.

I authorize the staff of RDV Sportsplex Pediatrics to contact the following individuals by phone to deliver test results, gather additional information, or authorize care in the following order:

(Note: Both parents/guardians are usually listed first, followed by any other individuals, if any.)

1. Name:______________________________ Relationship:_____________________ Phone:_________________
2. Name:______________________________ Relationship:_____________________ Phone:_________________
3. Name:______________________________ Relationship:_____________________ Phone:_________________
4. Name:______________________________ Relationship:_____________________ Phone:_________________

In my absence, I authorize the following individuals to accompany my child to the office of RDV Sportsplex Pediatrics, and seek medical care and authorize treatment.

1. Name:______________________________ Relationship:_____________________ Phone:_________________
2. Name:______________________________ Relationship:_____________________ Phone:_________________
3. Name:______________________________ Relationship:_____________________ Phone:_________________
4. Name:______________________________ Relationship:_____________________ Phone:_________________

Patient Name: ____ DOB: _______________

Patient Name: ____ DOB: _______________

Patient Name: ____ DOB: _______________

Patient Name: ____ DOB: _______________

Guarantor Name: ____ Relationship: _______________________

Guarantor Signature: ____ Date: _______________