AUTHORIZATION FOR MEDICAL TREATMENT of a MINOR

CHILD: _____ DOB: _____

I _____ _____ _____
Legal Custody/Guardian | Address (Street, City, Zip Code) | Phone Number

declare I have legal custody and am the guardian of the child mentioned above. I give the following permission:

- To attend appointments with mentioned child at Texas Pediatric Specialties and Family Sleep Center
- To receive medical information for the mentioned child
- To authorize medical treatment or medical procedures for the mentioned child

_____

_____ _____ _____
Full Name (ID must be presented at DOS) | Address (Street, City, Zip Code) | Phone Number

_____ _____ _____
Full Name (ID must be presented at DOS) | Address (Street, City, Zip Code) | Phone Number

_____ _____ _____
Full Name (ID must be presented at DOS) | Address (Street, City, Zip Code) | Phone Number

_____ _____ _____
Full Name (ID must be presented at DOS) | Address (Street, City, Zip Code) | Phone Number

Legal Guardian Signature: _____

Legal Guardian Printed Name: _____

Date: _____