



Emergency Contact/Consent

As the legal parent or guardian of _____ I hereby authorize the following person(s) to accompany my child to his/her appointment.

Name	Relationship	Phone Number
1.		
2.		
3.		

In my absence I give permission to the Providers to evaluate/treat my child. _____ (Initial)

I acknowledge that there may be labs and diagnostic tests to be performed. _____ (Initial)

If I have any question or concerns, I understand that I may contact your office. _____ (Initial)

In addition, I give consent for prescription pick up to the above identified individual(s).

Yes _____ (Initial)

No _____ (Initial)

Print Full Name:

Signature of Parent/Guardian

Date

*Healthy kids and teens.
Bright futures... one child at a time.*
Dr. Lily & Dr. Lito
232-PEDS(7337)