Clinic For Special Children
TREATING THE WHOLE CHILD

Authorization to Accompany Child

Patient Name: _____

Date of Birth: _____

There may come a time when parents/guardians cannot be available to bring their child/children to our office for care. During this time, while your child is in the care of someone else, we must have the information below to treat your child.

In presenting my child/ children for diagnosis and treatment, and when accompanied by the below listed individual, I hereby voluntarily consent to the rendering of such care, when including medical treatment by authorized members of the Clinic for Special Children and their medical staff, as may in their professional judgment by necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatments on child's conditions.

I have read this form and I understand its contents.

We/ I hereby give my consent to:

Name: _____

Relationship to Patient: _____

*** Please advise the above-named person to bring their ID and if necessary, a form of payment for the patient.*

I authorize the designated individual to arrange for routine or emergent medical treatment, if necessary, to preserve the health of our/ my child. I acknowledge that I am responsible for all charges in connection with the care and treatment rendered.

I understand it is my responsibility to inform this office of any change in my child's medical status. I understand if I fail to complete this form, that the Clinic for Special Children will not be able to treat my child, unless accompanied by anyone other than the registered parent/guardian as listed on the "Patient Registration Form".

Parent/ Guardian Printed Name: _____

Signature: _____ Date: _____