



Third Party Consent to Treat

I, _____, parent/ legal guardian of _____,
Name / Date of Birth

give permission for _____ / _____,
Name of person(s) / Relationship to Patient

to accompany my child to Lake Country Pediatrics, S.C. for medical care.

This authorization is given in advance of any specific diagnosis or care being required. I authorize this person(s) to consent to any x-ray examination, medical diagnosis, prescription, care, or treatment which is recommended by and/or rendered under the general or special supervision of any licensed medical provider of Lake Country Pediatrics S.C.

If third party is authorized to consent to routine shots (allergy shots, antibiotic shots, and vaccines), please initial here: _____

If there are any exceptions, please list them here:

This authorization shall remain effective until _____ turns 18 years of age,
(child's name)
or this document is revoked in writing, whichever occurs first.

In case of emergency, please contact me at _____.

Parent/Guardian Signature _____ Date _____