



Permission to Treat

Date: _____

To Whom It May Concern:

I am the parent of:

_____	_____
_____	_____
_____	_____

I give permission to the following listed person(s) to obtain medical treatment for the above-referenced child(ren) with a provider of Prosper Pediatrics or any facility which the provider deems necessary. This person(s) has my permission for medical decision making including but not limited to: Administration of medication, diagnostic or therapeutic procedures, admission to the hospital, etc.

Name:

Relationship:

_____	_____
_____	_____
_____	_____
_____	_____

In an emergency, the parent(s) may be reached at: _____

Parent Signature _____