PL Pediatrics,PLLC.-Parental Consent

Please complete this form if you do or do not you wish to have another party seek medical care for your child. Please fill out the correct section depending on your wishes.

Please fill out one section or the other.

I, _____ give PL Physicians, Inc. permission to allow _____, and _____ to bring my child _____ DOB___/____/_____to sick and follow-up appointments ONLY, along with seek medical care and treatment.

Parent/Guardian Signature_____

Relationship to patient:_____

I, _____ Do Not give PL Physicians, Inc. permission to allow my child _____ DOB___/___/____ to be brought to any appointments or seek medical care or treatment by anyone but myself.

Parent/Guardian Signature_____

Relationship to patient:_____