Village Pediatrics
5340 S Quebec St, Ste 210S
Greenwood Village, CO 80111
Ph: 303-850-7337
Fax:303-850-7362

CONSENT TO SEEK MEDICAL TREATMENT OF MINOR

In the event you are unable to bring your child in we must have this form on file for any person(s) over the age of 18 seeking medical care for your child.

I, _____, give my permission for the
(Print your name here, Parent or Guardian)

following person(s) to bring my children in for medical attention at Village Pediatrics:

_____ _____
(Print first and last name) **(Print first and last name)**

_____ _____
(Print first and last name) **(Print first and last name)**

Please allow the person(s) listed above to bring my child(ren), listed below, in to receive treatment by Village Pediatrics doctors and affiliates.

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

Childs Name: _____ DOB: _____

I may be reached at: (_____) _____-_____ with any questions or concerns.

_____ _____
Signature of Parent/Guardian Date