Authorization for Medical Treatment of Child

Child's Name :	Child's Date of Birth:
Drug or Serious Allergies	
Medications	
Known health conditions	
Other information the doctor should have about your child	

Person(s) who may bring child for care:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Authorized Care:

☐ YES ☐ NO	Diagnosis & treatment of illness/problem
☐ YES ☐ NO	Diagnostic tests (e.g. X-ray, blood draw, etc.) recommended by the doctor
☐ YES ☐ NO	Preventive care ("well check-up")
☐ YES ☐ NO	Screening tests as recommended by the doctor
☐ YES ☐ NO	Immunizations appropriate for age and history as recommended by the AAP and the ACIP

Please read each section below and initial indicating your understanding:

Initial here	This authorization is only effective for care at Cornerstone Pediatrics and does not need to be notarized. You may wish to provide your child's caretaker with a separate, notarized authorization for care elsewhere.
Initial here	This authorization will remain in your child's record and is effective from the date signed until the child is 21 and able to authorize his/her own care. If you wish this authorization to be effective only for certain dates, cross out the previous sentence and write effective dates here: Beginning on ____________________ and ending on __________________.
Initial here	The person to whom you are delegating authority must provide photo ID at EVERY visit to our office.
Initial here	You agree that we will bill your insurance plan if we have current insurance information & can verify coverage, and that you will be responsible for any amounts not covered by insurance. Insurance plans differ, and some tests, treatments and immunizations may not be covered under your plan. The person to whom you are delegating authority will be responsible to pay for any copay or fees due at the time of service unless you contact our office to make financial arrangements in advance.
Initial here	If immunizations have been authorized above and are administered, the current applicable Vaccine Information Statements will be given to the named adult accompanying the child.

Parent/Guardian Name:	Date of Birth:

By signing here and initialing the sections above, I/we give permission for any of the persons listed above to authorize any and all medical treatments for the child named at the top of the form at Cornerstone Pediatrics.

Mom/Guardian	Dad/Guardian
Home Phone: ______________________	Home Phone: ______________________
Work Phone:______________________	Work Phone:______________________
Cell Phone:______________________	Cell Phone:______________________
Email:______________________	Email:______________________

Parent/Guardian Signature:	Today's Date: