BEST ANGELS PEDIATRICS
7950 Cherry Ave. STE 105. Fontana, CA 92336. Phone: (909) 434-1657 Fax: (909) 231-6231

PARENTAL CONSENT FOR MEDICAL TREATMENT/ ASSIGNMENT OF CAREGIVER

CHILD'S INFORMATION

1st Child's name: _____ Date of Birth: _____/_____/_____

2nd Child's name: _____ Date of Birth: _____/_____/_____

3rd Child's name: _____ Date of Birth: _____/_____/_____

Address: _____City: _____ State: ____ Zip_____

CAREGIVER'S INFORMATION

1- Caregiver's Name_____ Phone Number (_____) _____

2- Caregiver's Name_____ Phone Number (_____) _____

3- Caregiver's Name_____ Phone Number (_____) _____

The above named caregiver is acting *in loco parentis* and shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, vaccines, diagnostic tests, physical exam, etc.), for the above named child, which may be required during my absence. This consent serves as permission for treatment at the offices of Best Angels Pediatrics. Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence.This authorization shall be effective until (Date): _____ / _____ / _____ unless earlier revoked in writing to Best Angels Pediatrics, by me.

Parent/Legal Guardian's Name: _____ **Phone:** (____) _____

Parent/Legal Guardian's Signature: _____ **Date**: ____ / ____ / _____