CONSENT TO TREAT MINOR CHILD/CHILDREN

I, ____, parent or legal guardian of child/children listed below, do hereby consent for ______________________________ to obtain medical care and authorize the administration of immunizations/treatment at Ahwatukee Pediatrics, P.C. while said child/children is/are under their care.

This authorization is effective from ___________________ to ____________________

Signature of Parent / Legal Guardian ____

Date ____________________________

Child's name ____________________________ Birthdate _______________________

Child's name ____________________________ Birthdate _______________________

Child's name ____________________________ Birthdate _______________________

Child's name ____________________________ Birthdate _______________________