CONSENT TO TREAT A CHILD

Child's Name: ______________________________ Date of Birth: ____________________

I, ____, give my permission as a Parent/Legal Guardian of the child above to the following persons to bring my child to purePEDIATRICS, PA and to consent to all physician discussions, telecommunications, immunizations, injections, medical therapies and procedures as they deem appropriate. In addition, they may call or use any telecommunications to contact our office or the doctor/staff to discuss medical care.

Name	Relationship to Child

If there is any change in the above list, I will inform the clinic in writing immediately.

____ ____________ __________________

Parent/Guardian's Signature Date Telephone Number

____ ____________

Witness' Signature Date

purePEDIATRICS, PA | 6750 W. Loop S., Suite 465, Bellaire, TX 77401 | 832-431-4336 | 832-460-6399 (Fax)