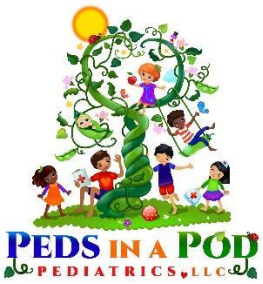

PARENTAL CONSENT FOR MEDICAL TREATMENT AND PAPERWORK

PATIENT NAME: _____ D.O.B_____

BIOLOGICAL PARENT/LEGAL GUARDIAN INFORMATION:

MOTHER: _____ FATHER: _____

CONTACT #: _____ CONTACT #: _____

PROXY(S) INFORMATION (STEP-PARENT, GRANDPARENT, ANYONE OVER THE AGE OF 18):

NAME: _____ CONTACT #: _____

RELATIONSHIP:_____

NAME: _____ CONTACT #: _____

RELATIONSHIP:_____

NAME: _____ CONTACT #: _____

RELATIONSHIP:_____

NAME: _____ CONTACT #: _____

RELATIONSHIP:_____

I understand that upon providing ID, only the above-named proxy(s) shall be authorized to accompany my child to Peds In A Pod Pediatrics, LLC, consent to medical care, sign and pick up forms/prescriptions.

Please note that due to the nature of some appointments and the need for a through history, a parent/legal guardian may need to be present. Please verify with our staff when making appointments whether a medical proxy is appropriate.

_____ _____

Parent/Legal Guardian Signature Date