MONTGOMERY PEDIATRICS INC.

9157 Montgomery Rd., Ste.100 · Cincinnati, Ohio · 45242-3260

Designation of Authorized Person to Consent for Treatment for Minor Child

In the event that I, (parents/legal guardians)______________________________, ______________________________ cannot accompany my child(ren) to Montgomery Pediatrics, I give permission to the following persons to consent to any necessary examination, medical diagnosis and/or medical care including, but not limited to, vaccines listed on the AAP's recommended vaccine schedule, to be rendered to the above named minor child under the general or special supervision and on the advice of any physician at Montgomery Pediatrics.

1. (Child's name) ______________________________ DOB ________________

List any chronic existing diseases or medical problems (asthma, diabetes, epilepsy, etc.):

____

List any medications your child is taking now:

____

List any known allergies, including medications:

____

2. (Child's name) ______________________________ DOB ________________

List any chronic existing diseases or medical problems (asthma, diabetes, epilepsy, etc.):

____

List any medications your child is taking now:

____

List any known allergies, including medications:

____

3. (Child's name) ______________________________ DOB ________________

List any chronic existing diseases or medical problems (asthma, diabetes, epilepsy, etc.):

____

List any medications your child is taking now:

____

List any known allergies, including medications:

____

4. (Child's name) ______________________________ DOB ________________

List any chronic existing diseases or medical problems (asthma, diabetes, epilepsy, etc.):

____

List any medications your child is taking now:

____

List any known allergies, including medications:

____

Authorized Person(s) – PLEASE PRINT CLEARLY

(person's name)____ (relationship) ____________________
(person's name)____ (relationship) ____________________
(person's name)____ (relationship) ____________________
(person's name)____ (relationship) ____________________
(person's name)____ (relationship) ____________________

The above named person(s) must bring your child's health insurance card and copay with them to the appointment. It is further agreed that if the parent or legal guardian wishes to discuss the medical care with the physician, a telephone consultation will be scheduled and the parent or legal guardian agrees to pay the cost of the telephone consultation at the time of the call. We do not bill insurance companies for telephone consultations; they are charged to and paid by the parent or legal guardian.

Expiration of Permission (check one):

□ This form will remain in effect until revoked by written notice
□ This form is VALID ONLY during the following time frame: Effective date: ______________ Expiration date: ______________

Signature of parent or legal guardian ____ Date ______________
Print Name ____
Signature of witness-MUST be 18 years or older__________________________________ Date ______________
Print Name ______________________________