Parental Consent for Medical Treatment

Dundalk Pediatric Associates
2112 Dundalk Ave.
Dundalk, MD 21222
Phone: (410) 284-1133 Fax: (410) 284-3371

Patient Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Information

Name: _____

Emergency Phone #: _____

Proxy(s) Information

Name: _____ Phone #: _____

Relationship: _____

Name: _____ Phone #: _____

Relationship: _____

I understand that **upon providing photo ID**, the above named proxy(s) shall be authorized to accompany my child to Dundalk Pediatric Associates and consent to medical care, including:

_____ Well-child visits, including immunizations and lab work as needed.

_____ Emergent visits regarding illness/injury.

Please note that due to the nature of some appointments and the need for a thorough history, a parent/guardian may need to be present. Please verify with our staff when making appointments whether or not a medical proxy is appropriate.

This document will remain in effect for one year after the date signed.

Parent/Guardian Signature: _____ **Date:** _____