Parental Consent for Medical Treatment and Paperwork

Dundalk Pediatric Associates
1792 Merritt Blvd
Dundalk, MD 21222
Phone: (410) 284-1133 Fax:(410) 284-3371

Patient Information

Patient Name:_____ Date of Birth:_____

Biological Parent/Legal Guardian Information

Mother:_____ Father:_____

Mothers Phone:_____ Fathers Phone:_____

Proxy(s) Information(Step Parent, Grandparent, anyone over the age of 18)

Name:_____ Phone:_____
Relationship:_____

Name:_____ Phone:_____
Relationship:_____

Name:_____ Phone:_____
Relationship:_____

Name:_____ Phone:_____
Relationship:_____

I understand that upon providing ID, the above named proxy(s) shall be authorized to accompany my child to Dundalk Pediatric Associates, 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 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/Patient's over the age of 18yr:
Signature: _____ Date: _____
Email Address_____