SUNFLOWER PEDIATRICS

MEDICAL AUTHORIZATION FORM

I/We, the undersigned, and parent(s) of ________________________________(Pt's name)___________(DOB) hereby authorize ______________________________((relative(s)/friend(s) name), to consent to any and all medical treatment for the above named patient to the best of their discretion in my absence. This includes, but is not limited to, treatment to relieve pain.

A photocopy of this authorization shall be deemed effective as if it were an original. This authorization shall remain in effect until___________(date)

Facility/Pediatric office: Sunflower Pediatrics

Parent: ____(Date)

Parent: ____(Date)