



Pediatrics, Inc.

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Board Certified Pediatrician

Authorization for Treatment in Absence of Parent or Guardian

Date: _____

I, _____ hereby authorize _____

to take my minor child, _____ for medical care and treatment

in my absence. I authorize the above named person to sign and authorize minor treatment and routine vaccinations in my absence.

I can be reached at _____ should a medical emergency arise and decision-making regarding my child be necessary.

This authorization is effective until _____.

Signature of Parent or Guardian

Date

Witness

Date