Starside Pediatrics

1518 Legacy Drive, Suite 110
Frisco, TX 75034

Newborn Child and Adolescent Medicine
Diplomats of the American Board of Pediatrics

Medical Authorization for Minors

Printed Name(s) of Child(ren): _____ Child(ren)'s DOB: _____

_____ _____

_____ _____

_____ _____

We (I) hereby authorize the following persons to authorize **medical treatment** for the above named child:

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

We (I) also authorize the following individuals to give consent for and sign for **immunizations** for the above named child:

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

_____ Relationship to child _____

We (I) also authorize Starside Pediatrics to copy and/or fax my Child's/children's' shot record(s), health statements, vision/hearing, or any other necessary health documents at my request without a signed authorization.

Parent or Guardian Name: _____

Parent or Guardian Signature: _____

Date: _____