MANSFIELD PEDIATRICS, PLLC

1825 Cannon Drive
MANSFIELD, TEXAS 76063
PHONE (817) 453-7770 / FAX (817) 453-7703

Non-Parental Authorization for Consent to Medical/ Surgical Care and Treatment

I, _____, parent / legal guardian of:

Child(ren):

_____ _____
NAME DOB

_____ _____
NAME DOB

_____ _____
NAME DOB

_____ _____
NAME DOB

Do hereby give my authorization and consent for my child (named above) to be seen by Providers at Mansfield Pediatrics, PLLC and consent to the medical/surgical care and treatment of my child(ren). I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical/surgical procedures or treatments deemed necessary for the well-being of my child(ren). This is also permission to bring my child(ren) for well checks and all necessary immunizations that are routinely given at the well visit.

I am, by this document, representing that I have the authority to consent for all medical/surgical care and treatment of said child(ren):

_____ _____ _____
Signature Relationship to Child(ren) Date

Authorized Parent / Guardian Names and Relationship (Mom/Dad):

_____ _____
Printed Name Relationship to Child(ren)

_____ _____
Printed Name Relationship to Child(ren)

Authorized Person(s) (Grandma/pa, Aunt, Uncle, Friend, Neighbor):

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)

_____ _____
Name Relationship to Child(ren)