

PEDIATRIC ASSOCIATES
OF WESTERN CONNECTICUT, L.L.C.

John E. Ertl, M.D. F.A.A.P.
Leon A. Baczkeski, M.D. F.A.A.P.
David B. Gropper, M.D. F.A.A.P.
Bruce W. Cohen, M.D. F.A.A.P.
Rachel R. Rothschild, M.D. F.A.A.P.
Kevin F. Ferguson, M.D. F.A.A.P.
Jamie L. Alon, M.D. F.A.A.P.
Carolinna M. Garcia, M.D. F.A.A.P.
José F. Arraiano, PA-C

Parental Consent for Treatment

Child's Information

Child's Name

Date of Birth

Home Address

Home Phone #

Parental/Guardian Contact

Phone #

Caregiver Information

Caregiver's Name

Phone #

The above named caregiver shall be authorized to consent to all medical treatment and/or medical procedures (including immunizations, diagnostic tests, etc.), for the above named child. This consent serves as permission for treatment by the physicians of Pediatric Associates.

Note: Consents are not required in emergency situations. I agree to pay for all services provided to my child in my absence.

This authorization shall be effective until: ____/____/____

Signature

Parent/Guardian

Date