

Pediatric Associates of Medford
Consent by Proxy

Authorization to Consent to Treatment for a Minor Child

I, _____ authorize the following individual(s)-
(ie: aunt, grandparent, and/or family friend)

1)

2)

3)

4)

to consent to an evaluation and treatment of my child, _____
at any medical visit to Pediatric Associates of Medford. This includes consent for
any immunizations my child may need at the time of the visit.

Date: _____

Signature of Parent of Guardian: _____