AUTHORIZATION FOR CHILD'S TREATMENT

BROOMFIELD PEDIATRICS
an affiliate of Community Reach Center

I am the Parent/Guardian of: _____ **DOB:** _____

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I hereby give Broomfield Pediatrics specific authorization to treat my child, including authorization to administer immunizations, when my child is brought to the practice by any of the following caregivers.

I further authorize the practice to triage or discuss with the designated caregivers, either in person or by phone, my child's symptoms and/or medical condition in order to assist and advise the caregiver concerning the immediate treatment options for my symptomatic child. This includes releasing relevant medical information to the caregiver, on a need to know basis

Please indicate name and relationship to patient:

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

Name:_____ **Relationship:** _____

_____ _____

Parent/Guardian **Date**