Assignment of Medical Care

I, (Parent / Legal Guardian) _____,

residing at (Parent / Legal Guardian's Address) _____

_____,

give permission for _____

and/or _____

to seek medical care for my child(ren) (Names and Birthdays)

_____

_____

in the event I am unable to accompany my child(ren) to the physician's office.

This authorization is for routine care and/or emergency care as deemed necessary by the physician and staff of Azle Pediatrics. I understand that in the event of an extraordinary emergency, Azle Pediatrics will make a reasonable effort to contact me and inform me of the situation.

I may be reached at the following numbers:

Home: _____ Work: _____ Cell: _____

I understand that this authorization is directed to the attention of Azle Pediatrics staff and to the physician and staff who may be required to treat my child in the event Azle Pediatrics staff is absent.

_____
Signature of Parent / Legal Guardian

_____ _____
Witness Second Witness (Required if via telephone)

_____
Date