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SUNSHINE PEDIATRICS
A Children's Mercy Affiliate

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Consent to Treat & Caregiver Authorization Form

Child's Name: _____

Date of Birth: _____

Parent / Legal Guardian

Parent/Guardian Name: _____

Relationship to Child: _____

Primary Phone: _____

Alternate Phone: _____

Authorized Caregiver Permission

I authorize the individual(s) listed below to bring my child to **Sunshine Pediatrics** for medical care when I am unavailable. These authorized caregiver(s) may: accompany my child to appointments, provide medical history information, consent to routine medical evaluation and treatment, consent to immunizations consistent with office policy, receive visit-related instructions and after-care information

Authorized Caregiver Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Limitations or Special Instructions (Optional)

Emergency Treatment Authorization

I authorize Sunshine Pediatrics providers to administer appropriate medical treatment in the event of illness or injury while my child is under the supervision of an authorized caregiver. The office will attempt to contact me using the numbers listed above. I understand that I remain financially responsible for all services rendered to my child, regardless of who brings my child to the appointment.

Parent / Legal Guardian Signature

I certify that I am the legal parent or guardian of the child listed above and grant permission as described.

Signature: _____

Printed Name: _____

Date: _____