Patient Name: _____ Date of Birth: _____

Capital Area Pediatrics

CAP Account #_____

MEDICAL AUTHORIZATION FOR ALTERNATE CAREGIVER

Child's Name: _____ Birth date: _____

Parent / Legal Guardian's Name : _____

Name of Authorized Adult: _____

Permission for medical treatment:

In my absence, _____ *(name of parent or legal guardian)* I authorize my child's caregiver, _____ (name of authorized adult) to seek services for my child (listed above) from Capital Area Pediatrics for treatment, including hospitalization, local anesthesia, office surgery(i.e. wart removal, incision and drainage), laboratory testing or injections of medication.

This authorization is effective from: _____ to _____. However, I understand that I can withdraw authorization at any time, with written notice.

Parent or Legal Guardians' Signature: _____

Date_____