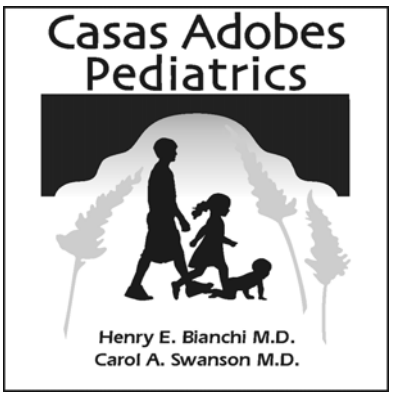

PEDIATRIC PERMISSION TO TREAT

I, _____do hereby grant permission to Henry Bianchi, M.D. or Carol A. Swanson, M.D. to treat my child _____ (date of birth: _____) in the event of an emergency or anytime he/she presents to the office requesting medical care.

Sometimes adolescents, 16 years and older, may come to the office alone. If your child may do so, indicate below:
My child may be seen without an adult escort: ☐ Yes ☐ No

Other people who have permission to bring my child for medical care:

Name	**Relationship**

_____ _____
Parent/Guardian Signature Date