DUPAGE PEDIATRICS, LTD

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Authorization for Medical Treatment of a Minor

I, the parent or legal guardian of ________________________________ born
(child's name)
_______________________________________, a minor, do hereby appoint
(birth date)
____to act on my behalf, in the event I cannot be
(name of person(s) authorized to bring child)

contacted to authorize necessary medical treatment while said minor is under his/her

care beginning on_____________________and ending on___________________________.
(start date) (ending date, can leave open ended)

I will be responsible for paying costs associated with such treatment. Said minor's insurance

coverage is with __________________________under identification number
(company)
____________________________________and group number_______________________.

DuPage Pediatrics, Ltd. (phone -630-810-0900, fax-630-810-0937) is the minor's pediatrician.

_______________________________ ____________________________________
Your Signature Your Name

____
Your Relationship to Child

____
Your Home Address, City, State, Zip Code

________________________________ _____________________________________
Your Home Phone Number Your Cell Phone Number

____
Other Emergency Contacts and Phone Numbers
03/27/2017