

**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 - parents/legal guardians do not need to be listed)

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