

# Glendora Pediatric Medical Group Inc.

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## AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize \_\_\_\_\_ (an adult into whose care the minor(s) has been entrusted) to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care of \_\_\_\_\_ (name(s) and address of minor(s) deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided.

This authorization is made under Family Code § 6910.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

Print Name: \_\_\_\_\_

Please Specify relationship to minor:

Parent with legal custody

Guardian with legal custody