PEDIATRIC AND
ADOLESCENT CARE

7500 Iron Bar Lane, Suite 120
Gainesville, VA 20155
Phone: 703-753-6772 (MSPA)
Fax: (888) 972-4515
www.milestoneskids.com

PARENTAL AUTHORIZATION FORM
For Another Adult to Take a Child for Medical Treatment

I give permission for the following to authorize medical treatment for my child in the event that I am not available.

Child's Name: ______________________________________ Date of Birth: ______/____/________

Child's Name: ______________________________________ Date of Birth: ______/____/________

Child's Name: ______________________________________ Date of Birth: ______/____/________

Child's Name: ______________________________________ Date of Birth: ______/____/________

Child's Name: ______________________________________ Date of Birth: ______/____/________

(Please use additional form for more than 5 children)

List two people on the lines below other than a parent/guardian who I authorize to take my children listed above for treatment:

Name: ____ Relation to Child __________________

Name: ____ Relation to Child __________________

Parent's Name (Printed): ______________________________________Date ____/_____/__________

Parent's Signature: ____

Contact Telephone: ____

NOTE: If, at any time, a person listed above no longer has your permission to authorize treatment or to take your child to Milestones Pediatric And Adolescent Care, it is your responsibility to inform us with a letter stating that you are withdrawing your permission.