Ptarmigan Pediatrics, LLC
3543 E Meridian Park Lp, Ste A, Wasilla, AK 99654
(ph) 907-357-4543; (fax) 907-357-4533

Parental Consent for Medical Treatment

►Child's Information

1. Child's Name _____ Date of Birth _____

2. Child's Name _____ Date of Birth _____

3. Child's Name _____ Date of Birth _____

Home Mailing Address _____ Primary Phone Number _____

City, State, Zip _____

The below named custodian(s) is/are acting in *loco parentis* and shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, diagnostic tests, etc.), for the above named child, which may be required during my absence.

►Custodian's Information

Custodian's Name _____ Relationship to child _____ Phone Number _____

Custodian's Name _____ Relationship to child _____ Phone Number _____

Custodian's Name _____ Relationship to child _____ Phone Number _____

This consent serves as permission for treatment at **PTARMIGAN PEDIATRICS, LLC.**
Note: Consents are not required in emergency situations.
I agree to pay for all services provided to my child in my absence.
This authorization shall be effective:

☐ **One year** from the date beside my signature or **until** ☐ _____ unless earlier revoked in writing by me to Ptarmigan Pediatrics, LLC.
Month / Day / Year

►Signatures

Print Parent / Legal Guardian's Name (circle one) _____ Phone Number (Cell / Work) _____

Signed Parent / Legal Guardian (circle one) _____ Date _____

Witness _____ Date _____