# PEDIATRICS OF AKRON, INC.
# 300 LOCUST ST. SUITE 200
# AKRON, OHIO 44302

## AUTHORIZATION FOR TREATMENT

****ALL INFORMATION /NAMES MUST BE PRINTED****

DATE: _____

I/WE _____
(MOTHER)

_____
(FATHER)

Give permission to the following person/persons to bring/obtain medical care for my child/children:

_____ (CHILD) _____ (CHILD)

_____ (CHILD) _____ (CHILD)

_____ (CHILD) _____ (CHILD)

*Continue on back if necessary*

**AUTHORIZED PEOPLE:**

Step parent: _____ _____

Grandparents: _____ _____

Sitters: _____ _____

Others: _____ _____

**Signed:** _____ _____

(MOTHER) (FATHER)

**ANY REVISION OF THIS LIST MUST BE GIVEN TO US IN WRITING AND MUST BE DATED**