ONE VISIT ONLY AUTHORIZATION FOR
PARENT OR GUARDIAN
TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize _____

(an adult into whose care the minor has been entrusted)

to consent to any medical or surgical treatment including but not limited to immunizations, laboratory testing or treatment including hospital care (if necessary) of

NAME OF MINOR_____

DATE OF BIRTH _____/_____/_____

as deemed advisable by a licensed physician or nurse practitioner of Pediatric Associates of Stockton.

This authorization is made under Family Code §6910.

Signed: _____

Print Name: _____

Dated: _____/_____/_____

Please specify relationship to minor:

_____ parent with legal custody _____guardian with legal custody

89 W. March Lane, Suite #1, Stockton, CA 95207

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