**ALTA LOMA PEDIATRICS**
**9710 19TH St. Rancho Cucamonga, CA 91737. Phone: (909) 581-0008 Fax: (909) 581-0030**

# PARENTAL CONSENT FOR MEDICAL TREATMENT/ ASSIGNMENT OF CAREGIVER

**CHILD'S INFORMATION**

Child's name: _____ Date of Birth: _____/_____/_____

Address: _____City: _____ State: ____ Zip_____

**CAREGIVER'S INFORMATION**

1- Caregiver's Name_____ Phone Number (_____) _____

2- Caregiver's Name_____ Phone Number (_____) _____

3- Caregiver's Name_____ Phone Number (_____) _____

The above named caregiver is 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, vaccines, diagnostic tests, physical exam, etc.), for the above named child, which may be required during my absence. This consent serves as permission for treatment at the offices of Alta Loma Pediatrics. 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 until (Date): _____ / _____ / _____ unless earlier revoked in writing to Alta Loma Pediatrics, by me.

**Parent/Legal Guardian's Name:** _____ **Phone:** (____) _____

**Parent/Legal Guardian's Signature:** _____ **Date**: ____ / ____ / _____