Sheboygan Pediatrics
FROM CRADLE TO COLLEGE

Return completed form, signed by parent/legal guardian, at or before your appointment to:

Sheboygan Pediatric Associates, S.C.
2920 Superior Avenue
Sheboygan, WI 53081
TEL:920-458-3331
FAX:920-458-1387

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, _____, being the parent or legal guardian of _____ grant the following authorization for medical and treatment, including immunizations and labs, of this minor by a health care professional at the appointment time scheduled on _____.

I grant permission to Sheboygan Pediatric Associates for evaluation and treatment of medical problems including immunizations and labs. I understand that should a major medical problem arise; an attempt will be made to notify me by telephone. In the event that I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary for said minor by a licensed physician.

Date _____ Parent/Guardian Signature _____

Medical Information (please print)

Minor Patient Name _____ Date of Birth _____

Allergies _____ Medications _____

_____

Other information that would be useful at this appointment _____

_____

Contact Information (please print)

For additional questions or a medical emergency, parents or legal guardians can be reached as follows:

Name _____ Relationship to Minor _____

Name _____ Relationship to Minor _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phones _____