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PEDIATRIC PARTNERS OF ZEPHYRHILLS, PA

TEMPORARY AUTHORIZATION CONSENT TO TREAT A CHILD

Date _____

I (We) _____
Name(s) and address(es) of parent(s)
_____

designate to _____
Name and address of designee

_____

the power to consent in our absence to medical care for our child(ren)

Names and Ages of Children

_____ _____

_____ _____

_____ _____

Parent(s) Phone Number(s) _____

Child(ren)'s Physician _____
At Pediatric Partners of Zephyrhills 6712 Dairy Rd Zephyrhills, FL 33542 Phone #: (813)782-6064

Medical Insurance Company _____ Policy #: _____

Dates of expected absence _____ to _____

Child(ren)'s medical history – Chronic conditions _____

Medications take on a regular basis _____

Allergies _____

Dietary or other restrictions _____

Parent(s) Signature(s) _____ Date _____