MEDICAL CENTER PEDIATRICS
30400 Telegraph Suite 101 Bingham Farms, MI 48025
5793 West Maple Road Suite 153, West Bloomfield MI 48322

Effective Date:

_______/_______/_______

End Date:

______/_______/________

Child's Name: ____

Date of Birth: _______/_______/________

I, _____________________________(parent/guardian), give ___________________________ (name of designated person) permisson to authorize treatment for the child named above.

Sign:____Date:____________________________

**Please send designated person with photo identification.