

PEDIATRIC ASSOCIATES
OF WESTERN CONNECTICUT, L.L.C.

John E. Ertl, M.D. F.A.A.P.
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David B. Gropper, M.D. F.A.A.P.
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José F. Arraiano, PA-C.
Andrea M. Fedor, PA-C.

Parental Consent for Treatment

Child's Information

Child's Name

Date of Birth

Home Address

Home Phone #

Parental/Guardian Contact

Phone #

Caregiver Information

Caregiver's Name

Phone #

The above named caregiver shall be authorized to consent to all medical treatment and/or medical procedures (including immunizations, diagnostic tests, etc.), for the above named child. This consent serves as permission for treatment by the physicians of Pediatric Associates.

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: ____/____/____

Signature

Parent/Guardian

Date