PROFESSIONAL ASSOCIATION FOR PEDIATRICS

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Heidi L. Benson, RN, MSN, FNP-BC
Lydia E. Ezzell, RN, MSN, FNP-BC

Permission to Treat Form

Date:______________________________

To Whom It May Concern:

I, ____________________________, guardian of _______________________________ give my
(Parent's Name) (Child's Name)

permission for ___________________________ to seek medical care and make medical decisions
(Caretakers Name)

for my child as necessary on my behalf from ___/___/20__ to ___/___/20__.

___________________________ Parent's Signature ____________________________________
Date

___________________________ Parent's Signature ____________________________________
Date

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