Olga L. Gomez M.D., P.A.

Children's Clinic

Medical Treatment Authorization and Consent

I/we, _____ being the (check one) ☐ parent(s) ☐ legal guardian

of _____ (child's name) authorize the caregivers below

to seek, obtain and consent to: (check all that apply)

☐ routine medical care and treatment ☐ hospitalization ☐ emergency medical care and treatment

☐ vaccinations ☐ procedures ☐ other:_____

for _____ (child's name) as deemed necessary by licensed medical or healthcare

professional. This authorization is for the time period when my/our child is under the care of:

Caregivers Information		
Full Name:	D.O.B:	Relationship to child:
Full Name:	D.O.B:	Relationship to child:
Full Name:	D.O.B:	Relationship to child:

Child's Information	
Child's Full Name:	D.OB:

Parent/ Guardian's Information	
Parent/ Guardian's Full Name:	D.O.B
Phone Number (C) :	Phone Number (W):
Email:	

Parent/ Guardian Signature:_____ Date: _____

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Autorización y Consentimiento de Tratamiento Médico

Yo/nosotros _____ siendo el ☐ padre(s) ☐ guardián legal

de _____ (nombre del niño (a)) autorizo al cuidador a continuación a buscar, obtener y dar consentimiento para: (marque todo lo que aplique)

☐ tratamiento de atención médica de rutina ☐ hospitalización ☐ atención y tratamiento médico de emergencia

☐ vacunas preventivas ☐ procedimientos ☐ other: _____

para _____(nombre del niño(a)) según lo considere necesario un médico o centro de atención médica autorizado profesional. Esta autorización es por el período de tiempo en que mi/nuestro hijo esté bajo el cuidado de:

Caregivers Information		
Full Name:	DOB:	Relationship to child:
Full Name:	DOB:	Relationship to child:
Full Name:	DOB:	Relationship to child:

Child's Information	
Child's Full Name:	DOB:

Parent/ Guardian's Information	
Parent/ Guardian's Full Name:	DOB:
Phone Number (C):	Phone Number (W):
Email:	

Parent/ Guardian Signature:_____ Date: _____

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