Medical Authorization for Treatment

I hereby authorize the physicians and nurse practitioners at Grayson Pediatrics, LLC to provide required medical treatment, in the opinion of the provider acting on behalf of our child(ren).

Sibling's Name: ________________ ☐Male ☐Female D.O.B.: ___________ Cell: ____________ Email: _______________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Sibling's Name: ________________ ☐Male ☐Female D.O.B.: ___________ Cell: ____________ Email: _______________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Sibling's Name: ________________ ☐Male ☐Female D.O.B.: ___________ Cell: ____________ Email: _______________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Sibling's Name: ________________ ☐Male ☐Female D.O.B.: ___________ Cell: ____________ Email: _______________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

Sibling's Name: ________________ ☐Male ☐Female D.O.B.: ___________ Cell: ____________ Email: _______________
Ethnicity: ☐Hispanic / ☐Non-Hispanic / ☐Unknown *Race*: ☐Asian / ☐Black / ☐Hawaiian / ☐White

You will need to fill out an additional Patient Medical History and Household information, birth/general history forms for each child listed above.

Signature of Patient, Parent or Guardian: _______________________ **Date**: ________________

Relationship to Patient(s) listed above: ___________________________________