Kid Approved Pediatrics, PLLC
11875 Coit Rd, Ste 100
Frisco, TX 75035

Authorization for Medical Care to Minors

I,_____, the parent or legal guardian of the minor(s) listed below:

Name_____ DOB_____

Name_____DOB _____

Name_____DOB _____

Do hereby authorize medical treatment by Kid Approved Pediatrics, PLLC

Name of the adult person(s) authorized to bring minor child in for medical treatment.

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Telephone number(s) where parent or guardian can be reached.

Home:_____Cell:_____Work:_____

Signature/Relation to minor_____ Date_____