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Permission to Treat

I _____ authorize Sears Pediatrics Center

Print name(s) of legal guardian(s)

and its personnel to deliver medical services to my child(ren):

Print child's name and date of birth

I/ We authorize the following people to bring my child for treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Legal Guardian

Date