JACKSONVILLE PEDIATRICS

PEDIATRIC THROUGH ADOLESCENT MEDICINE
2606 PARK STREET
JACKSONVILLE, FL 32204-4594
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RANDOLPH E. THORNTON, M.D.
NAN S. MCCLELLAND,M.D.
THOMAS P. STANLEY, M.D.
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RYAN CANTVILLE, D.O.
PAMELA S. WENTWORTH, A.R.N.P.

EMERGENCY CARE / CONSENT FOR TREATMENT FORM

Child's Name _____ D.O.B. _____

I hereby give permission to the above named doctors to direct any emergency medical treatment to my children during by absence.

It is understood that they will make every effort to contact me in case of medical emergency. It is further understood that if they are unable to contact me, that I give them this permission with my full consent.

If hospitalization is necessary, I direct the above named doctors to arrange admission. I will be financially responsible for all hospital expenses.

For non-urgent care (well child care, immunizations, minor illness, etc.) it is necessary for you to list the individuals to whom you have given permission to bring the child in for care. Please them below:

Name	Relationship to child (aunt, neighbor, etc.)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Date: _____ Signed _____

Witness _____