

Child Medical Care Authorization

(This must be filled out in entirety)

I _____, the undersigned parent of _____,

Hereby grant _____,

Permission to bring my child in for medical care at the medical offices of REYNOSO MD Medical Center.

This grant of permission shall begin on _____ and remain in effect until _____.

The above named guardian shall have the power to (initial all that apply):

____ Seek appropriate medical treatment or attention on behalf of the child as may be required by the
Circumstances, including, but not limited to, medical doctor and/or hospital visits.

____ Authorize medical treatment or medical procedures in an emergency situation.

____ Sign and release forms for sports, field trips or related activities.

Parent Signature

Date of Signature

8595 East Bell Road, Suite 103 Scottsdale, Arizona 85260 Phone: 480-659-1509 Fax: 480-659-0275