

Southwest Pediatrics

HITESH Z. SHAH, M.D., F.A.A.P.

CHARITY O. SANTIAGO, M.D.

CONSENT TO AUTHORIZE MEDICAL TREATMENT

I, _____ THE MOTHER/FATHER OF:

1. _____

2. _____

3. _____

4. _____

**GIVE PERMISSION FOR THE FOLLOWING PEOPLE TO
CONSENT TO MEDICAL TREATMENT INCLUDING BUT NOT
LIMITED TO IMMUNIZATIONS.**

1. _____

2. _____

3. _____

4. _____

PARENT

DATE
