My Kids
Pediatric Partners
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CONSENT FOR MEDICAL CARE

Permission is granted to the physicians and employees of My Kids Pediatric Partners, PC to do such procedures as may be necessary to diagnose, treat, and care for the needs of myself (if 18 years old or older), or of my dependent minor child including but not limited to routine office and laboratory procedures such as strep tests and throat cultures, urine studies, complete blood counts (CBC), hematocrits, bladder catheterization, removal of cerumen (ear wax), removal of foreign bodies, drainage of abscess, fracture care, medication injections, and treatment of skin lesions, warts, burns, and lacerations.

Patient Name: _____ Date of Birth:_____
(Please Print)

Signature of Custodial Parent or Guardian: _____

Date: _____

This authorization shall remain effective until such time that it is revoked in writing and delivered to My Kids Pediatric Partners, PC.