13768 Roswell Ave
Suite 115
Chino, CA 91710
Office: (909) 590-7356
Fax: (909) 364-1126

Effective Date:
___ / ___ / ___

End Date:
___ /___ / ___

Child's Name ____

Date of Birth _____ / _____ / _____

I, _____________________________________ (Parent/Legal Guardian of Above Child), give _____________________________________ permission to authorize medical treatment for the above child.

Primary Doctor _____________________________

Hospital ___________________________________

Hospital Phone (_____) _____ - _______

Insurance _________________________

Member ID# _______________________

Signed ____

Date _____ / _____ / _____

Relationship to Above Child ____________

Witnessed the above signature ____

Date _____ / _____ / _____