

Dr. Kumar for Kids
Board Certified Pediatrician

Consent for Non-Guardian to Authorize Treatment

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Effective Date:
___ / ___ / ___

End Date:
___ / ___ / ___

Child's Name _____

Date of Birth ___ / ___ / ___

I, _____ (Parent/Legal Guardian of child
mentioned above), 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 ___ / ___ / ___