PEDIATRIC EPILEPSY & NEUROLOGY SPECIALISTS

Permission to Treat

I (We) authorize _____ authorize
print name(s) of legal guardian(s)

Pediatric Epilepsy and Neurology Specialists and its personnel to deliver medical services to my child(ren):

_____
Print child's name and date of birth

_____
Print child's name and date of birth

_____
Print child's name and date of birth

_____
Print child's name and date of birth

I (We) authorize the following people to bring my child in for treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature of Legal Guardian *Date*