

# Parental Consent

Southern Oregon Pediatrics  
750 Murphy Road  
Medford, OR 97504  
541-789-4096

I, \_\_\_\_\_ Authorize

\_\_\_\_\_ Relation to patient \_\_\_\_\_

\_\_\_\_\_ Relation to patient \_\_\_\_\_

To seek medical care for the following patient(s):

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

Duration of time:

\_\_\_ Date of service only \_\_\_\_\_

\_\_\_ 1 Week

\_\_\_ 1 Month

\_\_\_ Range of Dates \_\_\_\_\_ to \_\_\_\_\_

\_\_\_ No expiration date

Guardian/Parent \_\_\_\_\_ Date: \_\_\_\_\_

Signature if you want revoked: \_\_\_\_\_ Date: \_\_\_\_\_