stellar
PEDIATRIC URGENT CARE

Authorization for Treatment of a Minor

Child's Name: _____
First Middle Last

DOB: _____

I, _____ (Parent/Guardian), do hereby give permission for medical treatment from a provider at Stellar of _____(Child's Name).

The following person(s) have my permission to have the child listed above treated by Stellar:

Name: _____
First Middle Last

Name: _____
First Middle Last

Name: _____
First Middle Last

Name: _____
First Middle Last

_____
Parent/Guardian Name Signature Date