Pure Joy PEDIATRICS

15405 SW 116th Ave, Suite 116 | King City, OR 97224
Phone: 503-420-8667| Fax: 971-512-3246 | www.PureJoyPediatrics.com

Minor Child Treatment Authorization

Patient's Name: _____ Patient's Date of Birth: ____/____/_____ Age: _____

Street Address: _____ City/State/ZIP: _____

I, _____ being the parent/guardian of _____ consent to treatment at Pure Joy Pediatrics, LLC and agree to treatment necessary by a medical or healthcare professional who is licensed. This authorization will be for the time when my child is under treatment at Pure Joy Pediatrics and is effective until revoked by me in writing.

This request and authorization applies to:

- ❍ All medical treatments deemed necessary for my child's condition.

Parent/Guardian's Details

Parent's/Guardian's Name: _____

Address: _____

Parent's/Guardian's Name: _____

Phone Number: _____

Patient Signature: _____ Date signed: ____/____/_____

Parent/Guardian Signature: _____ Date signed: ____/____/_____

(if Patient is under Age 18)