Portofino Pediatrics
Pediatric Consent Form
(In the Absence of the Parent of Guardian)

CHILD'S NAME: _____DOB _____AGE _____

I (We) the parent (s) or legal guardian (s) authorize the individual (s) named below to act in my (our) behalf with the full authority to grant permission for any medical treatment or surgical procedure that is in the best interest of the above named child in the opinion of the Portofino Pediatric providers, licensed to practice in the State of Florida. In addition, the provider is hereby authorized in an emergent situation to perform whatever acts that in his/her professional opinion that is in the best interest of the above-mentioned child. I understand that the provider may request to contact the parent/ guardian prior to providing medical treatment even though this consent is presented. Since medicine and surgery are not an exact science, it is acknowledged that no results can be guaranteed.

ADULTS THAT MAY CONSENT FOR MEDICAL TREATMENT IN MY (OUR) ABSENCE:
(Authorized individuals should also be listed in Privacy Practices)

Name: _____Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

This consent form will be in effect for 12 months from signing or less time if specified: _____

AUTHORIZED BY: (Both parents signature preferred, but not required)
By signing below, I certify that I am the legal parent or guardian of the child identified above and am acting within my authority in signing this Pediatric Consent form.

Mother (Printed): _____Father (Printed): _____

Signature: _____Signature:_____

Date: _____ Date:_____

Or

Legal guardian
(printed):_____

Legal guardian signature: _____Date: _____

ANY CHANGES TO THIS CONSENT MUST BE MADE IN PERSON AT THE PHYSICIANS OFFICE