The Pediatric & Young Adult Clinic
Ronda Dennis-Smithart, MD, FAAP
Christine Doyle, ARNP, CPNP
1417 A Avenue East, Suite 100
Oskaloosa, IA 52577-4202
We treat your kids like they 're R'KiDS

Authorization To Consent To Treat A Child

Date:_____

I (we) _____
Name(s) of parent(s) or guardian(s)

_____
Address(es) of parent(s) or guardian(s)

_____

authorization to _____
Name(s) of designate(s)

_____
Address(es) of designate(s) Phone #

the power to consent (in our absence) to medical care for our child(ren)

_____ _____
Name of Child DOB Name of Child DOB

_____ _____ _____ _____
Name of Child DOB Name of Child DOB

Parent(s)' Home, Work and Cellular Number(s) H/_____W/_____C/_____

Parent(s)' Home, Work and Cellular Number(s) H/_____W/_____C/_____

This authorization is in effect From_____ To_____

Child(ren)s' medical history

Chronic Conditions _____

_____

Medications that need to be taken on a regular basis _____

_____

Allergies _____

Dietary or other restrictions_____

Parent(s) or Guardian(s) Signature _____**Date**_____

Witness Signature _____**Date**_____

Revision date 09/04