Cherry Tree Pediatrics

CONSENT FOR TREATMENT

In my absence, I _____ the legal parent/guardian of _____ Birthdate: _____ give consent to the below mentioned person/persons to escort and to give his/her permission for treatment for the above mentioned child to the physicians and staff of Cherry Tree Pediatrics. This permission is also granted to the said person/persons regarding telephone advice unless otherwise indicated.

Name	Relationship	Phone Number

Parent/Guardian Signature: _____ Date: _____

2 Highland Park Drive, Suite 201 Uniontown, PA 15401 724-439-4479