West Plano Pediatrics, P.A.

6020 W. Parker Road, Suite 310

Plano, Texas 75093

972-608-0774

Authorization for Treatment

I consent to and authorize West Plano Pediatrics physicians, medical assistants, and other healthcare providers to perform appropriate healthcare examinations, diagnostic testing, and/or medication administration as deemed medically necessary.

Name of Minor(s)	DOB	Allergies/Special Conditions
______________________________	______/______/_______	______________________________
______________________________	______/______/_______	______________________________
______________________________	______/______/_______	______________________________
______________________________	______/______/_______	______________________________
______________________________	______/______/_______	______________________________

I, _________________________________, being the parent or legal guardian of the above minor(s), do hereby appoint the following person(s) (e.g., grandparents, babysitter, siblings over the age of 18 years, etc.) to act on my behalf in authorizing medical care for my child(ren) in my absence.

Name	Relationship to Patient	Phone #
______________________________	______________________________	_____-_____-________
______________________________	______________________________	_____-_____-________
______________________________	______________________________	_____-_____-________

Signature of Parent or Legal Guardian: ____ Date: _____/_____/________

Revised 12/2024