



Authorization to Treat Dependent Children

I, _____, parent/guardian of dependent child
_____, give my permission to First OnSite to render
medical care to my child.

The following listed individuals may bring my child to the office for medical care. **(Each person listed must be at least 18 years of age).**

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

I understand that the individuals listed above may be asked for identification when bringing my child to the medical clinic for medical treatment.

Employee: _____ Date: _____

Department Ext. #: _____ Personal Cell #: _____