Cohen & Sheinker MD PA

PERMISSION TO TREAT

Cohen & Sheinker MD PA has my permission to provide medical care and treatment to my child (ren) in my absence:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

To insure the security of our patients, please be aware that we will ask for picture identification of any person that is not a parent/legal guardian. If you will be sending your child (ren) with another person, please inform our office ahead of time.

Please provide a list of individuals who are authorized to bring your child (ren) to the office in your absence. These individuals are authorized to make medical decisions and discuss your child's health on your behalf.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Parent/Legal Guardian Signature: _____

Date: _____