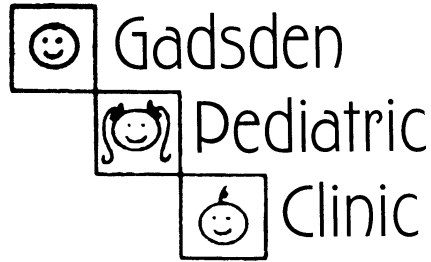


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## TREATMENT AUTHORIZATION FORM

Patient's Name: \_\_\_\_\_

I authorize the following persons to present my child to Gadsden Pediatric Clinic for medical care in my absence, and to sign for immunizations. I give Gadsden Pediatric Clinic permission to treat any and all medical conditions during this and subsequent visits.

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_