Birmingham Pediatrics + Wellness Center Caregiver Consent for Medical and/or Emergency Treatment (When parent not present)

I give my consent to:					
1) Full Name:(Here after "Caregiver)		Phone:			
Address:	City:		State:	Zip:	
who will be caring for my child(re six(6) months, after six (6) month			eriod can NOT	be longer than	
Month Date	Year through	Month	Date	Year	
to arrange for routine or emergence child/dependent or in the event the scheduled for a routine exam at his	at my child is injured or il	l while under t			
Birmingham Pediatrics + Wellnes 3270 West Big Beaver, Suite 400 Troy, MI 48084	s Center				
In making medical decisions on mattempt to call me. However, if m such decisions regarding such treatheir authorized designee. If needebenefit of my child/dependent, I a information bearing upon my child respecting such treatment. I do no contacting me if this form is signed. Dependents included in this conse	edical care becomes urger atment as deemed appropried to make any treatment authorize the caregiver to a d/dependent's health and at hold Birmingham Pedia and present at the time	nt, I give perminate by the med decisions by the request, obtain, relevant to any trics + Wellnes	ssion to the car dical doctor/pro e caregiver on review and ins such decisions s Center respon	regiver to make ovider, hospital or my behalf for the spect any and all s to be made nsible for	
Name		D	ОВ		
Name			ОВ		
Name		<u>D</u>	ОВ		
Name		D	ОВ		
Name		D	ОВ		
I acknowledge that no guarantees on the condition of my dependent and treatment rendered to my dep	and that I am responsible	for all the cha			
Signature of Parent/Legal Guardia	an	D	ate		
Printed Name of Parent/Legal Gu	ardian	<u></u>	ate		

January 2015