Village Center Pediatrics

Tammy Maschino, MD Kimberly Edgmon, MD

Karyl Knopps, APRN-CNP

AUTHORIZATION FOR TREATMENT OF MINOR

Child's Name: _____ Date of Birth: _____

I _____ (Parent/Guardian), do hereby give permission for medical treatment from Tammy Maschino, MD, Kimberly Edgmon, MD and /or Karyl Knopps, APRN-CNP to the above named child.

The following person(s) have my permission to bring the child listed above:

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

Parent Signature: _____ Date: _____