PERMANENT TREATMENT PERMISSION

Please print:

I, ____________________________, give permission to Pennridge Pediatric Associates to examine and treat my son or daughter, _________________________ , in my absence for accidental injury, illness or well care including immunizations when accompanied by _________________________.

I hereby give permission for _________________________ to sign, in my absence, the vaccine information statement which is information about the disease and the immunization and to initial the administration record which verifies the receipt of said information.

By signing this form you are stating that you understand and agree to all the above.

______________________________
PARENT/LEGAL GUARDIAN SIGNATURE

______________________________
DATE

______________________________
WITNESS

______________________________
DATE

Lawn Avenue
Professional Center
711 Lawn Avenue
Sellersville, PA 18960
215-257-2727
Fax: 215-257-8785

GVH
Outpatient Center
270 Main Street
Harleysville, PA 19438
215-256-1999
Fax: 215-256-6130
TEMPORARY TREATMENT PERMISSION FORM

I hereby give my permission to Pennridge Pediatric Associates and Grand View Hospital to treat my son/daughter, ___________________________________________, while I am away from ___________________________ to ___________________________.

I understand that in cases of major significance such as fracture, appendicitis or any illness requiring admission that additional consents may be necessary for treatment and that Pennridge Pediatric Associates will make every attempt to reach me. I CAN BE REACHED AT ___________________________.

ADDRESS

My child is allergic to the following drug(s):_____________________________________________________

My child routinely takes the following medication(s):_____________________________________________

I give permission for my child to receive a DT/TD (if needed): ( ) Yes ( ) No

His/her last tetanus immunization was: _______________________________________________________

I understand in cases of acute emergency when Pennridge Pediatric Associates personnel have attempted to notify me but are unable to reach me, that this permission form will suffice for treatment until I am notified. While we are away, _____________________________________________ is(are) under the care of

PATIENT(S)

CAREGIVER

RELATIONSHIP TO PATIENT(S)

CAREGIVER TELEPHONE NUMBER

PARENT NAME PRINTED

SIGNATURE

DATE

WITNESS

DATE

Lawn Avenue Professional Center
711 Lawn Avenue
Sellersville, PA 18960
215-257-2727
Fax: 215-257-8735

GVH Outpatient Center
270 Main Street
Harleysville, PA 19438
215-256-1999
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