PPA Pennridge Pediatric Associates

• *Pediatrics*
Edward P. Rothstein, M.D., FAAP
Thomas J. Hipp, M.D., FAAP
Ronald L. Souder, M.D., FAAP
Thomas I. Kennedy, M.D., FAAP
Deborah R. Faccenda, M.D., FAAP
Richard T. Kratz, M.D., FAAP
Erik F. Lamberth, M.D., FAAP
Deborah J. Bolanowski, M.D., FAAP
Anuta Dolha, M.D., FAAP
Kelly Moretski, CRNP

• *Pediatric Habilitation*
Ronald L. Souder, M.D., FAAP

PERMANENT TREATMENT PERMISSION

Please print:

I, _____, give permission to Pennridge Pediatric Associates to
NAME OF PARENT/LEGAL GUARDIAN

examine and treat my son or daughter, _____
PATIENT NAME(S)

_____, in my absence for accidental injury, illness

or well care including immunizations when accompanied by

_____, _____ .
CAREGIVER(S) RELATIONSHIP TO PATIENT

I hereby give permission for _____, _____ to
CAREGIVER RELATIONSHIP TO PATIENT

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: 215-257-8735

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

Pennridge Pediatric Associates

• *Pediatrics*
Edward P. Rothstein, M.D., FAAP
Thomas J. Hipp, M.D., FAAP
Ronald L. Souder, M.D., FAAP
Thomas I. Kennedy, M.D., FAAP
Deborah R. Faccenda, M.D., FAAP
Richard T. Kratz, M.D., FAAP
Erik F. Lamberth, M.D., FAAP
Deborah J. Bolanowski, M.D., FAAP
Anuta Dolha, M.D., FAAP
Kelly Moretski, CRNP

• *Pediatric Habilitation*
Ronald L. Souder, M.D., FAAP

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
PATIENT NAME(S)

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 _____,
TELEPHONE NUMBER

_____
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
Fax: 215-256-6130