Consent To Treat Form

I hereby give authorization to the following named individuals to accompany my child/children for treatment at Georgetown Pediatrics, PC:

_____

_____

_____

_____

_____

This includes, but is not limited to, medical evaluation, treatment and administering of immunizations.

_____ _____

(Parent Signature) **(Date)**

_____

Child's Name Date of Birth

_____

Child's Name Date of Birth

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Child's Name Date of Birth

_____

Child's Name Date of Birth

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Child's Name Date of Birth

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Child's Name Date of Birth