

BEVERLY HILLS PEDIATRICS

CAREGIVER CONSENT FOR MEDICAL AND/OR EMERGENCY TREATMENT

I give my consent to _____,
(here after "caregiver") – Full Name

who will be caring for my dependent for the period _____ through _____, to
arrange for routine or emergency medical care and treatment necessary to preserve the health of my
dependent, in the event that my dependent is injured or ill while under the care of the caregiver or
scheduled for a routine exam at:

BEVERLY HILLS PEDIATRICS
8530 Wilshire Blvd, Suite 520
Beverly Hills, CA 90211

In making medical decisions on my behalf for the benefit of my dependent, I direct that the caregiver
attempt to contact me. However, if medical care becomes essential, I give permission to the caregiver to
make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or
their authorized designee. In furtherance of any treatment decisions to be made by the caregiver on my
behalf for the benefit of my dependent, I authorize the caregiver to request, obtain, review and inspect
any and all information bearing upon my dependent's health and relevant to any such decisions to be
made respecting such treatment.

Dependents included in this consent form are as follows:

_____ Name	DOB
_____ Name	DOB
_____ Name	DOB
_____ Name	DOB
_____ Name	DOB

I acknowledge that no guarantees have been made to me as to the effect of such examinations or
treatment on the condition of my dependent and that I am responsible for all reasonable charges in
connection with the care and treatment rendered to my dependent during this period.

Signature of Legal Guardian

Date

Name of Legal Guardian (print)

Phone contact for Legal Guardian