CONSENT FOR MEDICAL CARE

Date: _____

I, _____, am the parent or legal guardian of

_____, _____.
(name of child) (Date of Birth)

Due to my work schedule, I cannot accompany my child for his/her appointment.

I authorize Dr. Rhonda Berkowitz to provide my child with medical services as Indicated. This authorization expires one year from this date unless otherwise noted.

Sincerely,

_____ (signature of Parent/Guardian)