Post Road Pediatrics, LLP
616 Boston Post Road
Sudbury, MA 01776
978-443-6005

ALTERNATE CARE GIVER FORM

I authorize the following individual(s) to bring my children to their appointments:

Name:_______________________________ Relationship to child:__________________
Name:_______________________________ Relationship to child:__________________
Name:_______________________________ Relationship to child:__________________
Name:_______________________________ Relationship to child:__________________

I attest that the above named individuals are all 18 years of age or older as of this date.

I authorize the above named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, vaccinations, procedures, and hospitalization. **Post Road Pediatrics, LLP** may relay any medical information about my child necessary for the above named individual(s) to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings the child, and that under most circumstances a follow-up call to me personally should not be necessary.

I agree to hold **Post Road Pediatrics, LLP** and its staff harmless for any disagreement between the above named individuals and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

Children covered by this consent (list full names and date of birth):

1.)____
2.)____
3.)____
4.)____
5.)____

Parent/guardian's name: ____

Signature:____

Date:________________________