

CENTRAL COAST PEDIATRICS INC.
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TEMPLETON CA 93465
(805) 434-3796

Parental Consent Form

I do hereby authorize and consent to all medical treatment deemed necessary to treat my daughter/son in my absence. I authorize the following person(s) to make decisions on my behalf.

Patient Name: _____

Birthdate: _____

Date of Service: _____

Parent/Legal Guardian: _____

Contact Number: _____

Signature: _____

Accompanied By: _____

Relationship: _____

By typing my name as my signature, I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.