



**Consent for Care**

With my signature:

I hereby authorize consent for medical treatment and care for the patient listed below.

In the rare event that I cannot be reached, I hereby authorize Allegro Pediatrics to institute any necessary care for this patient in my absence. This includes hospitalization in the case of an emergency.

This form must be signed by a parent or guardian if the patient is under the age of 18.

**I accept**

**I decline** and understand that the patient will not be able to receive medical care at Allegro Pediatrics.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Signature of patient or parent/guardian if patient is under 18

\_\_\_\_\_  
Printed Name of Person Signing

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

This form will be retained in the patient's medical record.