Elgin Pediatrics
Karen English, MD, FAAP

Authorization for service

I _____, the legal parent or guardian the listed child, authorize the following persons to accompany my child/children to Elgin Pediatrics and to authorize medical treatment. I do/do not want to be called regarding the diagnosis and disposition of my child/children.

I do/do not want to allow my child/children to be examined or receive treatment by Dr. Karen English, or any provider at Elgin Pediatrics unaccompanied by an adult because of my/our absence or unavailability. I agree to cooperate by being present with said minor at all times possible or when requested.

This consent will be in effect until it is terminated by written notice received by this office.

Name of child _____

List of Accompanying Adults

1. _____
2. _____
3. _____
4. _____
5. _____

_____
_____

Signature of Parent/Legal Guardian Date