



**THE
PEDIATRIC
GROUP**
OF SOUTHERN CALIFORNIA

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29525 Canwood Street Suite 250
Agoura Hills CA 91301 • 818.735.5555

Parental Consent

Date: _____

Patient Name: _____

Parent/Guardian Name: _____

I, _____, am granting permission to the person(s) listed below to make medical decisions for the above mentioned minor in my absence. The person(s) named below is aware that they have been granted this temporary permission and is not to be considered as permanent guardianship.

The Pediatric Group and/or The Allergy Group of Southern California and its physicians and medical staff have my permission to treat the above mentioned minor in my absence.

- This authorization **does** include the administration of vaccinations.
- This authorization **does not** include the administration of vaccinations.

Person(s) included in this authorization: _____

 Parent/Guardian Signature

 Date