Preferred Pediatrics
824 W. Frontier Lane • Olathe, Kansas 66061 • (913) 764-7060

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CONSENT TO TREAT

Date: _____

Patient Name_____

DOB: _____

I give permission for_____to bring my child to Preferred Pediatrics and receive appropriate medical care, treatment, and immunizations if needed.

I can be reached at _____for any further questions.

_____

Legal Guardians Signature

_____

Relationship to child

Olathe Fax: 913-764-8059