



Preferred Pediatrics

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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 Guardian's Signature

Relationship to child

Olathe Fax: 913-764-8059

