Sugar Land Pediatric Center
REQUIRED SIGNATURES

CONSENT TO TREAT

I am the parent/guardian of _____. I have the legal right and responsibility to obtain and consent to medical treatment for this patient. I voluntarily authorize and consent to such medical care and treatment that Dr. Aliya Ahmed / Dr. Nina Singhal believe are necessary for this child. I understand that by signing this form, and by bringing this child to this medical office for care, I am giving permission to the doctors and other health care providers in this office to provide treatment to this patient as long as he/she is a patient of this practice.

_____ _____ _____
***Signature of Parent/Guardian Relationship to patient Date**

DELEGATION OF CONSENT

I hereby authorize (when I am unavailable to give consent) the following individual (s) _____, whose relationship to the patient is _____, to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the State of Texas. This consent includes medical intervention and elective as well as emergency care. Immunizations may be given by this consent. This delegation shall be valid until I withdraw this delegation of consent.

_____ _____ _____
***Signature of Parent/Guardian Relationship to patient Date**