FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.

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CONSENT TO TREAT

I, _____, being the parent or legal guardian of _____hereby voluntarily give my consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment and immunizations by a licensed physician and the physician's assistants and designees as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my child's condition.

The minor named in this consent form may receive all treatment provided according to the generally accepted standard of medical practice with the following limitations: (if none, write NONE)_____ .

I also give permission for the following persons to seek and obtain the above mentioned medical care for my child to my absence: (Please Print)

_____ _____

_____ _____

These authorizations shall remain effective until revoked in writing.

_____ _____

Date Parent/Legal Guardian