AUTHORIZATION FOR UNACCOMPANIED CHILD CARE

East Bay Pediatric and Adolescent Medicine
234 Maple Avenue • Barrington, Rhode Island 02806
(401) 247-1644 Fax: (401) 247-4961

I hereby authorize East Bay Pediatric and Adolescent Medicine to examine and treat my minor child,

_____, birth date: _____, when he/she is unaccompanied.

I understand that I may revoke this consent at any time.

Signature of Parent/Patient or Guardian:

_____ Date: _____