RONALD A. GOODSITE, M.D., FAAP
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PERMISSION TO TREAT

SPECIAL POWER OF ATTORNEY-IN LOCO PARENTIS
KNOW ALL MEN BY THESE PRESENTS:

THAT I, ____

DO HEREBY APPOINT ____

WHOSE ADDRESS IS ____

AS MY TRUE AND LAWFUL ATTORNEY TO ACT AS MY AGENT IN HAVING CUSTODY AND CONTROL OF MY CHILD(REN):

FIRST	*MIDDLE*	*LAST NAME*	*DATE OF BIRTH*	*ALLERGIES*

FOR ALL MATTERS RELATING TO THEIR HEALTH AND WELFARE IN MY ABSENCE. This shall include, but not be limited to, matters concerning their dental and medical requirements such as office exams, testing, medications, minor surgery and anesthesia, hospital care or emergency room/urgent care evaluation and treatment, and to execute all authorizations, releases, consents or other paperwork which may be required for their treatment. I acknowledge that I retain all legal rights and responsibilities for their welfare and that I have contracted with ______________________________ insurance company, contract card # ______________________________ to pay for medical treatment for my children.

This authority expires 1(one) year from the date of signing.

______________________________ ______________________________
SIGNATURE PRINTED NAME

______________ ______________________________ ______________
PHONE NUMBER ADDRESS DATE

THIS FORM MUST BE NOTARIZED BY A NOTARY PUBLIC IN ARIZONA