



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

## CONSENT FOR CARETAKER- AUTHORIZATION FOR CARE

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

when he/she is accompanied by

\_\_\_\_\_, relationship to patient \_\_\_\_\_.

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

Signature Parent/ Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_