



**Sonia Gidwani, MD, PLLC**  
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**our kids' MD**

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## Assignment of Medical Care

Instructions: ORIGINAL ON FILE at Our Kids MD office. THREE COPIES to parent(s)/legal guardian(s)

I, (Parent/Legal Guardian) \_\_\_\_\_

Residing at (Parent/Legal Guardian Address) \_\_\_\_\_

Give my permission for (Names of Day Care Providers or Relatives)

\_\_\_\_\_

And/or \_\_\_\_\_

To seek medical care for my child(ren), (names and birthdays)

\_\_\_\_\_

\_\_\_\_\_

In the event I am unable to accompany my child(ren) to the physician's office.

This authorization is for routine care and/or emergency care as deemed necessary by the physician and his assistants. I understand that in the event of an extraordinary emergency, the office of the physician will make a reasonable effort to contact me and inform me of the situation.

I may be reached at the following numbers:

Phone: \_\_\_\_\_ Pager: \_\_\_\_\_ Cell: \_\_\_\_\_

A message may be left at the following number: \_\_\_\_\_

I understand that this authorization is directed to the attention of Our Kids MD staff and to the physician and staff who may be required to treat my child(ren) in the event Our Kids MD staff is absent.

\_\_\_\_\_  
(Signature of Parent/Legal Guardian)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)