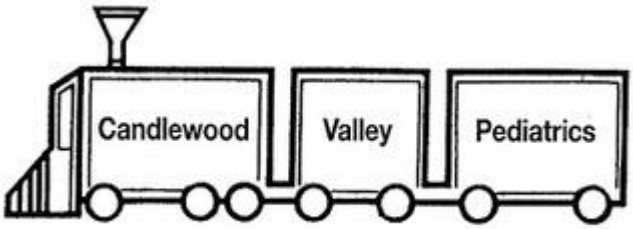
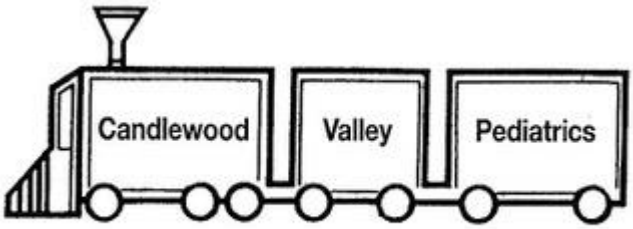


. . . caring for infants, children & adolescents

Evan R. Hack, MD
Frank Fanella, Jr., MD
Matthew G. Abel, MD
Kristi F. Beck, MD
Stephanie T. Tiso, MD
Betsy Meyer, PA-C
Karla Rosati, PA-C

120 Park Lane Rd.
Suite A-101
New Milford, CT 06776
(860) 355-8190
fax (860) 355-3856

The doctors and staff at Candlewood Valley Pediatrics wish to provide your children with the best health care possible. For that reason, it is very important that at least one parent or legal guardian accompany their minor child to their appointments. Our doctors must be able to obtain a detailed history from each patient, including family medical histories, drug or food allergies, history of symptoms, or any other pertinent information that will enable our doctors to treat each patient thoroughly and effectively. If, for any reason, a parent or legal guardian cannot accompany their minor child to an appointment, it is required that a Permission to Treat form (available below) be completed, signed, and brought to the appointment with whomever is accompanying your child. Our doctors cannot provide efficient service if they are forced to track down a parent or guardian during an office visit. Lack of pertinent information during a visit could result in your child's not receiving the treatment or vaccination that may be required, thus creating the need for additional visits for which you will be charged. Our Permission to Treat form is located on our website. Please be sure this form is completed in its entirely before your child's appointment. If the person accompanying your child does not present a completed Permission to Treat form before the appointment, your child's appointment may have to be rescheduled. Your child's health is our first priority. Working together, we can see to it that their healthcare needs are addressed appropriately and efficiently. Thank you for your cooperation.



Evan R. Hack, MD
Frank Fanella, Jr., MD
Matthew G. Abel, MD
Kristi F. Beck, MD
Stephanie T. Tiso, MD
Betsy Meyer, PA-C
Karla Rosati, PA-C

120 Park Lane Rd.
Suite A-101
New Milford, CT 06776
(860) 355-8190
fax (860) 355-3856

Permission to Treat

Parent/Guardian name _____

Person accompanying child/Relationship to child _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

Child's name _____ DOB _____

☐ I give permission for the above-named person to accompany my child to his/her office visit.

☐ I give permission for the doctor to administer any vaccines required at this visit.

☐ I give permission for the doctor to administer any necessary treatment at this visit.

☐ I do NOT give permission for any vaccines to be administered at this visit.

☐ I do NOT give permission for treatment to be administered at this visit.

Parent/Guardian signature _____ Date _____