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Toya Tillis, M.D.

Child's Name: _____

Date of Birth: _____

List two people on the lines below other than a parent/ guardian that you give permission to authorize medical treatment if you are not available.

Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

Primary Doctor: _____

Hospital: Pomona Valley Hospital Medical Center
Phone: (909)865-9500

Name of Insurance: _____

Member ID #: _____

Signed _____ Date:

Signors Relationship _____

Witnessed the above signature _____ Date: