CONSENT TO TREAT A MINOR(S)

This form is giving permission for someone (i.e. Grandma, Uncle) other than parent/guardian to bring patient(s) in to see doctor.

PATIENT NAME: _____

DATE OF BIRTH: _____

SIBLING NAME: _____ DATE OF BIRTH: _____

SIBLING NAME: _____ DATE OF BIRTH: _____

SIBLING NAME: _____ DATE OF BIRTH: _____

I, _____,(name of parent/guardian) the guardian of the above names of child(ren) giving the following adults permission to make decisions regarding:

1) The necessary and/or routine treatment of my child(ren) but not limited to examinations, injection(s), immunizations and/or diagnostic procedures including X-rays or laboratory analysis. I understand that only myself and those listed below will have the authority to authorize treatment. I also authorize treatment of my teen 18 yrs and older without requiring the presence of an adult.

NAME (AUTHORIZED CAREGIVER(S)	PHONE	RELATIONSHIP TO PATIENT
NAME (AUTHORIZED CAREGIVER(S)	PHONE	RELATIONSHIP TO PATIENT
NAME (AUTHORIZED CAREGIVER(S)	PHONE	RELATIONSHIP TO PATIENT

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment could be refused or delayed. I understand that in an emergency, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

The authorization will remain in effect unless stated in writing to withdrawal such consent for treatment of a minor. I will notify Biskup and Segui Pediatrics PC of any change in the above information.

I have read all the information on this sheet to certify that the information I have provided here is true and correct to the best of my knowledge.

PRINT PARENT/GUARDIAN NAME: _____

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____