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Consent to Treat Patient – Without Parent/Legal Guardian Present

AUTHORIZATION:

I have the legal right to preauthorize Schoolhouse Pediatrics and its personnel to deliver routine medical treatment and services to my child. Routine Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunization, injections, and lab work (examples: throat or nasal swabs, blood draws, urine catheterizations, wart treatment with liquid nitrogen, minor burns, suture removals, etc.).

I _____ request and authorize Schoolhouse Pediatrics and its personnel to deliver routine medical care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Child's Name: _____ DOB: _____
Allergies: _____
Current Medications: _____
Chronic Conditions: _____

LIMITATIONS:

Identify any specific limitation on the kinds of medical services for which this authorization is given. (If none, state "none".)

Parental contact information for questions regarding treatment of the child:

Parent name: _____

Contact info: (c) _____ (h) _____ (w) _____

Address: _____ City: _____ St. _____ Zip _____

I hereby authorize _____ to bring my child to his/her appointments if I am unable to attend. I understand that medical advice will be relayed to them on my behalf. I understand and agree that the signature and dates on this form will not expire without written notice or in case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

Relationship to Child of above named person: _____

Parent or Legal Guardian Signature: _____

Date: _____