# CONSENT for TREATMENT of MINOR

Date

| Print Full Name of Patient | Month | Day | Year |
|---|---|---|---|
| | | | |

I________________________________________________
Print Full Name of Parent or Guardian

legal guardian of________________________________________
Print Full Name of Patient

give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child including but not limited to, examinations, injection, immunization and/or diagnostic procedures including X-ray or laboratory analysis. I understand that only myself and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations) of my teen (16 years and older) without requiring the presence of an adult. However, if my teen needs immunizations and comes alone, a parent/guardian must be available by phone for verbal consent.

| Name (of Person Authorized to Permit Treatment) | Phone | Relationship to patient |
|---|---|---|
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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.

This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I will notify New England Pediatrics, LLP of any changes in the health status of my children or the above information.

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

Signature: ____________________________________ Date: ______________________

## Whom May We Contact In Case Of Emergency?

| Name | Phone | Relationship to patient |
|---|---|---|
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