Permission to Treat by Parents or Legal Guardian For Minor Children

South Lake Pediatrics

I hereby authorize consent for medical examination and treatment, to include but not limited to, obtaining blood samples, x-rays, medication administration, and patient education by the healthcare providers of this facility. I understand that I have the right to be informed by my physician of the nature and purpose of any proposed procedure, alternative methods of treatment, and an explanation of the risks and benefits of both. This form is not a substitute for that explanation.

The consent of a parent or guardian is required for the treatment of minors. A minor is any person under 18 years of age. This practice requires that a minor be accompanied by a parent or guardian. This consent gives us permission to treat the patient for those items specified below. This consent will remain in effect for one (1) year, or until you notify us otherwise.

As the parent or guardian, I _____ , give

permission for _____ to be seen at South Lake Pediatrics

according to the guidelines below:

☐ May come to the Doctor's office with _____ .

I give permission for the following:

☐ Well Child checks or routine physical examinations
☐ Immunizations
☐ Allergy Shots
☐ Sick visits typically covered under a general consent
☐ Treatment needed during a sick visit

I can be contacted at _____ or _____ if additional information is needed during exam.

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Witness Signature Date

NAME:

DATE OF BIRTH:

CHART NUMBER: