Name:_____

Chart #:_____

University Pediatrics

Permission for Treatment of Minor Children

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 University Pediatrics. 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 risk 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. University Pediatrics requires that a minor be accompanied by a parent or guardian. This consent gives us permission to provide treatment to the patient for those items specified below. This consent will remain in effect for one year or until you notify us otherwise. Any person listed to seek treatment for a child on this consent form must be 18 years old or older. Minor children can not seek treatment for other minor children or siblings.

As the parent or guardian, I _____ , give

permission for _____ to be seen at

University Pediatrics according to the guidelines stated below.

Name of Adult to Accompany Child: _____
Relationship to child: _____

I give permission for the following treatments:

- ☐ Well Child Exams
- ☐ Immunizations
- ☐ Sick Visits
- ☐ Nurse Visits
- ☐ Laboratory Tests

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

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Witness Signature Date