

Consent to Treat Unaccompanied Minor

I, _____ (parent/legal guardian), give permission
for

Associates in Pediatrics and its providers to evaluate and treat my child:

Child's Name: _____ Date of Birth: _____

for medical concerns when they arrive to the office unaccompanied by a parent or legal guardian.

This consent includes:

- Routine medical care (well visits, sick visits, immunizations)
- Diagnostic testing as deemed necessary by the provider
- Emergency care if required, with attempts made to contact me as soon as possible

I understand this consent remains in effect until (date) _____ or until I revoke
it in writing.

Parent/Guardian Name: _____

Signature: _____ Date: _____

Phone Number(s): _____

Office Use Only:

Witness Name: _____

Witness Signature: _____ Date: _____