

The Pediatric Center PC

126 Morgan Street
Stamford, CT 06905

CONSENT FOR TREATMENT OF MINOR

I, _____, legal guardian of _____ give the following adults permission to make decisions regarding the necessary and or routine treatment of my child including but not limited to, examination, 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	Phone	Relationship to patient
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 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 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. I will notify the Pediatric Center PC of any changes in the health status of my children or the above information.

Whom may we contact in case of emergency?

Name _____ Relationship _____ Phone _____

Completed by: _____ Date _____

Signature _____

Date as of 04/03/03