beansprout PEDIATRICS

Consent to Treat Minor

Caregiver other than Parent/Guardian
Grandparent, step parent, nanny . . .

_____ _____ M F ___/___/___
first last date of birth

_____ _____ M F ___/___/___
first last date of birth

_____ _____ M F ___/___/___
first last date of birth

I, _____ legal guardian of the above named child(ren) give the following adults (listed below) permission to make decisions regarding the necessary and/or routine treatment of my child(ren) including but not limited to, examinations, injection, immunization and/or diagnostic procedures including X-ray or laboratory analysis.

I understand that only myself, and other legal parent or guardian 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. This consent does not authorize changes in demographics or signing consent forms by any person(s) other than legal parent or guardian.

Authorized caregivers listed must present photo identification, this will be scanned to patient(s) medical record for future verification

_____	____/ ____/ ____	_____	_____
name of authorized caregiver	date of birth	relationship to child	phone
_____	____/ ____/ ____	_____	_____
name of authorized caregiver	date of birth	relationship to child	phone
_____	____/ ____/ ____	_____	_____
name of authorized caregiver	date of birth	relationship to child	phone

I understand that any person bringing the patient in for treatment not listed above must have a signed & dated letter of consent from 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, 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 canceled. I will notify Beansprout Pediatrics of any changes in the above information. I have read all the information on this sheet and certify that the information I have provided here is true and correct to the best of my knowledge.

_____ _____ ____/____/ _____
mother/guardian printed name mother's signature date

_____ _____ ____/ ____ / _____
father/guardian printed name father's signature date

Beansprout Pediatrics
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