beansprout PEDIATRICS

CONSENT TO TREAT A MINOR

Caregiver other than Parent/Guardian

PATIENT NAME **DATE OF BIRTH**

last	first	m	d	y
	sibling	m	d	y
	sibling	m	d	y

I, _____
FULL NAME OF PARENT OR GUARDIAN

legal guardian of the above named child(ren) give the following adults 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 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 (authorized care giver(s)	phone	relationship to patient
Name (authorized care giver(s)	phone	relationship to patient
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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 an 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 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.

SIGTNATURE	RELATIONSHIP TO MINOR	DATE