CONSENT FOR TREATMENT IN THE ABSENCE OF A PARENT/GUARDIAN

I hereby give permission and written consent to Pediatric Alliance, PC, its physicians, employees, agents, and servants to render any and all medical treatment as deemed necessary to my child(ren) listed below, who are minors, in my absence.

_____ _____

_____ _____

_____ _____

_____ _____

Select one:

- ☐ This permission applies to whomever accompanies my child(ren) to the office.
- ☐ My child (age 16, 17, or 18) has my permission to be seen unaccompanied.
- ☐ This permission applies only to the people who are listed below:

_____ _____

_____ _____

Parent/Legal Guardian
Signature:_____ Date: _____

Witness: _____ Date: _____

If the patient is a minor under 18 years of age, his or her consent is acceptable for the following reasons:

☐ Married ☐ High School Graduate ☐ Pregnancy/birth of child