

CONSENT TO TREATMENT OF MINOR CHILD

1. Use a separate form for each child.
2. Complete form by filling in child's name and date of birth.
3. Sign and date the appropriate line. Include your telephone number
4. Ask another family member or a friend to witness your signature by signing and dating the bottom line.
5. Send completed form (s) to your Forest Park Pediatrics pediatrician

I understand that my child should, if at all possible, be accompanied by me at any time he/she appears for medical treatments and/or diagnosis.

I further agree to make every effort to be present whenever my child is in need of such treatment and/or diagnosis

However, on those occasions when it is impossible for me, or another adult designated by me, to accompany said child to the Forest Park Pediatrics physician designated below, or such other medical facility designated by that Forest Part Pediatrics doctor, I request that the Forest Park Pediatric physician use his/her best judgment in deciding what treatment, procedures, medications, and/or diagnostic procedures administered to this child until after they have been administered.

Finally, I understand that I may revoke this consent at any time, and that nothing herein prevents me from accompanying such child whenever he/she appears for treatment of diagnosis

Childs Last Name _____ First _____ MI
 Date of Birth _____ Physician _____ MD
 Parent/Legal Telephone Date
 Guardian's Signature _____ Signed _____
 Date
 Witness _____ Signed _____