PEDIATRIC ASSOCIATES OF WESTERN CONNECTICUT

CONSENT TO TREAT A MINOR

By law, generally, any child under the age of 18 years old cannot be seen by a Licensed Provider without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name:_____ **DOB:**_____
Last **First**

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Last **First**

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Last **First**

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Last **First**

For those occasions when you may not be with your child, please list those individuals who may give us consent in order to see your child:

Accompanying Adult	**Relationship to Patient**	**Phone #**
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LIMITATIONS:

- ☐ Check here if you wish to give consent for the minor to receive medical care with the above accompanying adult, with an end date of: (End Date) _____.
- ☐ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effective from: _____ until:_____.

AUTHORIZATION:

I (**parent/legal guardian name-please print**) _____ request and authorize Pediatric Associates of Western CT and its personnel to deliver medical care to my child listed above as may be deemed necessary in the diagnosis and treatment of the minor child. I am also aware that the accompanying adult is responsible for payment of the patient portion of the visit at the time of service. I have the legal right to authorize Pediatric Associates of Western CT and its staff to deliver medical treatment and services to my child. Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, lab work (examples: throat or nasal swabs, blood draws, urine catheterizations, etc.).

I have read, understand and give my consent to the above.

Parent/Legal Guardian (Signature)	**Relationship**	**Date**