

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
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 CAREGIVER(S))	PHONE	RELATIONSHIP TO PATIENT
NAME (AUTHORIZED CAREGIVER(S))	PHONE	RELATIONSHIP TO PATIENT
NAME (AUTHORIZED CAREGIVER(S))	PHONE	RELATIONSHIP TO PATIENT

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 New England Pediatrics, LLP 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.

SIGNATURE	RELATIONSHIP TO MINOR	DATE
-----------	-----------------------	------