Parental/Guardian's Consent to Treat a Minor Accompanied by Another Adult

I give permission to ____
Name of Accompanying Adult to

consent to the treatment of my son/daughter

________________________________ ________________________________
Name Date of Birth

by Pediatric Care P.C

I also agree that test results and/or medical information may be released to the above named adult. This will include authorization for immunizations Y __ N __

____ ______________________
Signature of Parent or Guardian Date

*This form expires does not expire unless revoked in writing by the parent or guardian.

- -

Treatment to Unaccompanied Minors

I hereby grant Pediatric Care P.C. permission to treat my child

____when they
Name Date of Birth

arrive at the office unaccompanied.

This will include authorization for immunizations Y __ N __

____ ______________________
Signature of Parent or Guardian Date

*This form does not expire unless revoked in writing by the parent or guardian.

- -

I give ____________________________________

Authorization to pick up prescriptions Y ___ N___ (ID REQUIRED)

____ ______________________
Signature Date
*This form does not expire unless revoked in writing.

Pediatric Care P.C.
27790 W Highway 22, Suite 7
Barrington, IL 60010
847 382-7337 847 382-7377 FAX