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

I give permission to _____
Name of Accompanying Adult(s)

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.
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