

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

I give permission to \_\_\_\_\_  
Name of Accompanying Adult(s) and relationship

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.  
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### Treatment to Unaccompanied Minors

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

\_\_\_\_\_  
Name Date of Birth \_\_\_\_\_ when they

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.  
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I give \_\_\_\_\_  
Relationship to me

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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