



Consent to Treat Patient – Without Parent /Legal Guardian Present

AUTHORIZATION:

I have the legal right to preauthorize Cedar Park Pediatric & Family Medicine and its personnel to deliver routine medical treatment and services to my child. Routine Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, urine catheterizations, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations)

I _____ request and authorize Cedar Park Pediatric & Family Medicine and its personnel to deliver routine medical care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Child's Name: _____ DOB: _____

Allergies: _____

Current Medications: _____

Chronic Conditions: _____

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none")

Parental contact information for questions regarding treatment of the child:

Parents name: _____

Contact info: (c) _____ (h) _____ (w) _____

Address: _____ City _____ St. _____ Zip _____

I hereby Authorize _____ to bring my child to his/her appointments if I am unable to attend. I understand that medical advice will be relayed to them on my behalf. I understand and agree that the signatures and dates on this form will not expire without written notice or in case that a minor becomes the age of 18, and that a photocopy of this form is considered valid as the original.

Parent or Legal Guardian (pleas print) Relationship Date

Parent or Legal Guardian (Signature)