kids+ pediatrics

Consent for Treatment in the Absence of a Parent or Guardian

I give my permission to **Kids Plus Pediatrics**, its physicians, employees, agents, and partners to render any and all medical treatment deemed necessary in my absence to my child(ren) listed below:

_____ _____

_____ _____

_____ _____

Please Select One:

_____ This permission applies to whomever accompanies my child(ren) to the office.

_____ My child (age 16, 17, or 18) has my permission to be seen unaccompanied.

_____ This permission applies only to the people listed below:

_____

_____

_____

Your Preferred Pharmacy: **Pharmacy Phone #:**

_____

Parent / Legal Guardian Signature: **Date**:

_____

If the patient is under 18 years of age, his or her consent is acceptable for these reasons:

_____ Married _____ High School Graduate _____ Pregnancy/Birth