BaysidePediatrics
children & young adults

# CONSENT TO TREAT MINORS FORM WITHOUT PARENT/LEGAL GUARDIAN PRESENT

**Purpose: This form may be used to allow a patient under the age of eighteen (18) but over the age of fifteen (15) to attend appointments, consent to and authorize routine healthcare treatment and services without the presence of a parent, legal guardian, or proxy decision maker.**

For some families, it may be more convenient to allow teenage patients (age 15-18) to attend appointments without the presence of a parent or legal guardian. If you would like to authorize your child to attend appointments, consent to and authorize routine medical care, interventions, and immunizations without a parent or legal guardian present, please review and complete the following form.

Authorization:

I hereby authorize my child, _____, (Date of birth: _____), to attend, consent to and authorize routine health care treatment and services for

☐ Appointment on (date): _____only.

☐ Any appointment for specified time period: _____.

☐ Other: _____

I understand that routine medical care and interventions may include but are not limited to: medical evaluation, physical exam, x-rays, lab work (examples include: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, cleaning of minor bumps, minor suturing of lacerations, removal of simple cysts, contraceptive care, and incision and drainage of abscesses). Bayside Pediatrics also may give immunizations, allergy shots or intramuscular/intravenous antibiotics pursuant to the consent of the proxy. I hereby empower and grant the child/patient listed above permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of himself/herself/themselves and to receive protected health information directly relevant to, and for purposes of, his or her care or payment related to this care.

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:

Parent's Name: _____ Phone: _____

Parent's Name: _____ Phone: _____

I hereby indemnify and hold harmless Bayside Pediatrics, and all their officers, agents, employees, attorneys, directors, insurers, affiliates, subsidiaries, related corporations, successors, heirs and assigns from any and all liability for acting in reliance on this authorization. The individual appointed as proxy (listed above) is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization.

This authorization is valid for the time frame specified above unless withdrawn in writing to Bayside Pediatrics or restricted by time frame as noted above. Only one parent's signature is required.

_____ _____ _____ _____

Signature of Parent/Legal Guardian Date Signature of Parent/Legal Guardian Date