

CONSENT FOR TREATMENT IN THE ABSENCE OF A PARENT OR GUARDIAN



Kids First Pediatric Partners
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I give my permission and written consent to Kids First Pediatric Partners, its practitioners, employees, agents and partners to render any and all medical treatment deemed necessary to my child(ren) listed below in my absence.

_____	_____
_____	_____
_____	_____
_____	_____

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:

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