University Hospitals

NAME OF OFFICE PRACTICE: **SANDUSKY PEDIATRICIANS**

PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

Instructions:

Section # 1) Please complete if you wish to authorize someone besides a parent/legal guardian to bring in your child, such as a step-parent, grandparent or babysitter.
Section # 2) Please complete if you wish to authorize your child coming alone.
Section # 3) PLEASE SIGN IN THE *SIGNATURE BOX AT THE BOTTOM TO AUTHORIZE EITHER OR BOTH

SECTION # 1: ACCOMPANIMENT Consent by someone other than a Legal Guardian

I, the Legal Guardian, _____, of the minor child(ren), give my consent for (*print minor child(ren's) names*):

_____

_____

_____

_____ to be accompanied by the individuals listed below to office visits and treatment that requires only general consent I have already signed the General Consent form included in the Financial Registration.

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

SECTION # 2: NO ACCOMPANIMENT BY AN ADULT or Legal Guardian Consent

Please complete this section ONLY if you consent for your minor child to transport himself/herself to office visits and treatment that requires only general consent without a Legal Guardian present.

My minor child(ren) (*print names of minor child(ren) you are authorizing*):

_____

_____ has my permission to transport himself/herself to receive general treatment that does not require general consent, which I, (*print name of legal guardian*)_____ as guardian, have already given.

SECTION # 3: *LEGAL GUARDIAN SIGNATURE

I understand that this consent is in place until revoked by me and/or the expiration of one year.
You can contact me by phone:

Home:_____Cell:_____Work:_____

Legal Guardian Signature:_____Date:_____

Relationship of Legal Guardian to child(ren:_____

(*Internal Use: data entered & scanned per patient. Initials/date:_____*)