Mali&Mali
PEDIATRICS

Consent for Treatment of a Minor without a Parent or Legal Guardian Present

Child's Name:_____DOB:_____

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I give my permission for my child to be medically evaluated and treated at Mali & Mali Pediatrics P.C. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation.

This consent applies to:

1. Complete Well Visit exam (accompanied by an adult).
2. Sick Patient Visit.
3. Hearing, Vision and Blood Pressure Screening.
4. Immunizations.
5. Evaluation and Treatment.
6. Referral to an outside agency for services not provided in our office (i.e. labs, x-ray or hospital).

Please list any services you do not consent to in your absence:

_____

_____

My child will be accompanied by:

- Him/Herself
- Caregiver (name)_____
- Other(name and relationship)_____

I give permission for the medical staff to share any relevant health information with the person accompanying my child.

_____ _____

Parent or Guardian's signature /Date Parent or Guardian's name printed

Phone number where parent or guardian can be reached:_____