Anderson Hills PEDIATRICS

CONSENT TO TREATMENT OF MINOR

Note: This form authorizes treatment of minor by persons other than parent/legal guardian

I _____ give Anderson Hills Pediatrics, Inc. permission to treat/test my child in
(Parent/Guardian)
connection with a prior diagnosis, including but not limited to, the administration of allergy medication.

Name of Minor Child: Date of Birth:

_____ _____

I further consent that the following individual(s), who may accompany the minor child specified above, may authorize treatment/testing in connection with a prior diagnosis and/or in connection with a new diagnosis and that such individual(s) is authorized to pick up any prescription or medication (including a controlled substance) provided to the minor child. I understand that such authorization does not cover consent to major surgery or any treatment provided outside the offices of Anderson Hills Pediatrics, Inc.

Name	Relationship to Minor Child
_____	_____
_____	_____
_____	_____
_____	_____

Check one of the following boxes:

☐ This notice is effective only on the following date(s): _____

☐ This notice is effective from the date below until revoked.

I understand that this notice will not expire unless revoked by me in writing.

_____
Parent/Guardian – Print Name

_____ _____
Parent/Guardian - Signature Date

VERBAL CONSENT OBTAINED FROM PARENT/GUARDIAN

Name of Parent/Guardian: _____
Date: _____
Verbal consent effective only on the following date: _____
Name of individual documenting consent: _____
Form sent to parent/guardian to follow-up on verbal consent on (insert date): _____