Consent for Treatment of a Minor

Date: _____

In the event that I am unable to bring my child (ren) to the office, I,

_____, being the parent or legal guardian of:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Hereby grant consent for the following persons to authorize any necessary examination, medical diagnosis, treatment and/or medical care to be rendered to the above named minor(s) that is recommended by any of the ESD Pediatric Group providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize use of this form from _____ to _____.

Parent/Guardian Signature: _____