CONSENT TO TREAT MINOR CHILDREN

Please complete form in its entirety

I, _____, parent or legal guardian of

Patient name: _____,

Patient date of birth: _____, do hereby consent to any medical care, including but not limited to medication changes, administration of immunizations or any other medical care determined by the physician or nurse practitioner to be necessary for the welfare of my child while said child is under the care of Englender, Sper and Drasnin, MD's, Inc. (dba ESD Pediatric Group) and I am not reasonably available by telephone to give consent. I allow ESD Pediatric Group to file for insurance benefits to pay for the care received. I understand that ESD Pediatric Group will have to send my child's medical record information to my insurance company.

This authorization is effective from _____ to _____.

_____ _____

Parent/Legal Guardian Signature Date

This consent form will remain in the above referenced patient chart and is valid for the period of time documented above. Should there be any changes to this consent, a new form is required to be completed.

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family address: _____

Telephone:

Parent Name: _____ Mobile #_____ Work #_____

Parent Name: _____ Mobile #_____ Work #_____

Effective: 02/15/2024