Green Hills Pediatric Associates

Consent to Treatment of a Minor When Parents/Guardians are Temporarily Unavailable

Patient Name _____ DOB _____

I give permission to the physicians and nurses of Green Hills Pediatric Associates to treat my child in my absence. I authorize any medical treatment necessary in my absence and in the event of an emergency for the well-being of the minor mentioned above.

It is understood that this consent is given before any specific diagnosis or treatment and allows the physician to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who can consent to treatment (please print):

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   I give permission for _____ (child's name), who is 16 years or older, to be treated unaccompanied. In the event the provider needs to speak with me, I can be reached at (telephone number) _____.

2. Medical concerns: _____
3. Known allergies: _____
4. Medications _____

Name of Parent or Legal Guardian*: _____Relationship to Child:_____
(Print Name)

Contact Number(s): _____

Address: _____City, State, Zip: _____

*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork.

This Consent is effective until withdrawn in writing by the child's parent or guardian or until the child turns 18. I understand that I am responsible for notifying Green Hills Pediatric Associates of any changes.

Signature: _____ Date: _____