Consent to Treat

I, _____, parent/legal guardian of:
Patient:

_____ _____
NAME Date of Birth

Do hereby give my authorization and consent to my child (named above) to be seen by (Kidsville Pediatrics PLLC),and/or any physician or nurse practitioner at Kidsville Pediatrics PLLC, consent to the medical/surgical care, behavioral health, allergy testing or treatment, immunotherapy or treatment, vaccinations, and treatment of my child.

Additionally, I hereby authorize and grant that the below named person(s) has/have permission from the natural parents to sign for any medical or surgical procedures, treatments, or immunizations deemed necessary for the well-being of my child(ren). This is also permission to bring my child(ren) for well checks and all necessary immunizations, behavioral health appointments, lab-work, allergy testing, immunotherapy, or rapid testing that are routinely given at the well visit or any sick visit. The duration of this consent is indefinite and continues until revoked in writing.

- **Is there any custody agreement we should be aware of? _Yes / No_____**
- **<u>If yes, please provide documentation at the first appointment</u>. parents/guardians must disclose any custody order, possession order, restraining order, or medical decision-making limitation. not just "custody agreement."**

Authorized Person(s):

_____ _____ _____
NAME Relation to patient Contact #

_____ _____ _____
NAME Relation to patient Contact #

I am, by this document, representing that all information regarding authority to present the child for treatment is true and I have the authority to consent for all medical/surgical care and treatment of said child(ren):

_____
Signature Date