

## NAME OF OFFICE PRACTICE: SANDUSKY PEDIATRICIANS

## PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

Internal Use: Entered per child. Date/initials:

## **Instructions:**

<u>Section # 1)</u> Please complete if you wish to authorize someone besides a parent/legal guardian to bring in your child, such as a step-parent, grandparent or babysitter.

Section # 2) Please complete if you wish to authorize your child coming alone.

Section # 3) PLEASE SIGN IN THE \*SIGNATURE BOX AT THE BOTTOM TO AUTHORIZE EITHER OR BOTH

Please draw an X across form if you do not wish to authorize either. Thank you.

I, the Legal Guardian,	, of the minor children:
	Birthdate:
	be accompanied by the individuals listed below to office visits and treatment
that requires only general consent. I	have already electronically signed the University Hospitals General Consent.
Name	Relationship
Name	Relationship
Name	Relationship
Please complete this section ONLY if	MPANIMENT BY AN ADULT or Legal Guardian Consent  you consent for any of your minor children to transport himself/herself to ires only general consent without a Legal Guardian present.
Please complete this section ONLY if office visits and treatment that requ  1. Minor Child's Name:	you consent for any of your minor children to transport himself/herself to ires only general consent without a Legal Guardian present.  Birthdate:
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