Office use only. Patient MRN: _____

CONSENT FOR TREATMENT

I give my permission for Pediatric Center for Wellness to treat my child and/or children listed below, according to the standards of care defined by the American Association of Pediatrics (AAP)
and the realm of medical necessity as deemed appropriate by the treating Provider.

(Child 1) _____ (Child 2) _____

(Child 3) _____ (Child 4) _____

_____ (Print Name) _____ (Date)

_____ (Signature of Parent /Guardian)

OPTIONAL: AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD (ie. Nanny, Grandparent, Step-Parent, and/or teen by themselves)

I,_____ (Please Print), do hereby consent and authorize Pediatric Center for Wellness and its Providers and Staff to examine and/or treat my child/children in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments.

I give the Providers and Staff permission to treat my child/children in my absence with whatever treatment plan they deem necessary and appropriate. I understand that I will be contacted for a verbal consent if treatment plan includes vaccines, and the best number to reach me for this is: _____.

_____ _____
Signature Date

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD.