Karle Medical Group, P.C.
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Consent to Treat Patient – Without Parent /Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: _____DOB:_____
Last First Middle

Allergies: _____
Current Medications: _____
Chronic Conditions: _____

For those occasions when you may not be with your child, please list those individuals who may give us **consent** to see your child:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

LIMITATIONS: Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none")

_____

□ Check here if you wish to give consent for the minor to receive medical care without an accompanying adult, which shall be in effect for:
□ Date_____ Only
□ Indefinitely, unless revoked by written communication

AUTHORIZATION:
I (parent/legal guardian name)_____ request and authorize Karle Medical Group, P.C. and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child, I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service. I have the legal right to preauthorize Karle Medical Group, P.C. and its personnel to deliver routine medical treatment and services to my child. Routine Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, urine catheterizations, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations) I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____
Parent or Legal Guardian (please print) Relationship to Patient

_____
Parent or Legal Guardian Signature Date