CONSENT FOR TREATMENT OF A MINOR

Patient Name: ____ Date of Birth: _______________________

I authorize Lone Tree Pediatrics (LTP) to treat my child listed above and provide the following services should his/her condition require it per the judgement of a LTP provider, including but not limited to:

- Routine medical care such as diagnosis and treatment of illness/injury or prescription medications
- Diagnostic testing (e.g., x-ray, lab testing, etc.)
- Well child visits, including recommended immunizations
- Emergency care, including referral to hospital or emergency room if needed

As long as the medical care is considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved. I impose no specific limitations or prohibitions regarding treatment. I agree to hold LTP free and harmless from anu claims, suits for damages or complications that may result from such treatment.

In order to provide the best medical care for your child, we recognize there are times when you are unable to attend your child's appointment. For your convenience, we provide this authorization to allow medical care for your child in your absence. Please review the information below. Initial the sections(s) that are applicable.

☐ **CONSENT TO PERMIT CERTAIN INDIVIDUALS TO ACCOMPANY CHILD FOR TREATMENT:**

I, ____, hereby authorize the following individual(s) to accompany my child to Lone Tree Pediatrics for the provision of medical services, and to view or discuss my child's Protected Health Information (PHI). This form has no expiration date, and any changes must be made in writing. Name(s) or stepparent, grandparent, nanny/au pair/babysitter/other and relationship to child:

____

____

These individuals are able to authorize procedures such as (check authorized categories: Immunizations Lab Orders X-rays

☐ **ONLY PARENT/GUARDIAN MAY ACCOMPANY CHILD FOR TREATMENT TO LONE TREE PEDIATRICS:**

I, ____, DO NOT authorize anyone other than the child's father, mother and /or guardian to accompany my child to Lone Tree Pediatrics for the provision of medical services.

☐ **CONSENT TO TREAT UNACCOMPANIED MINOR AT LONE TREE PEDIATRICS:**

I, ____, request and authorize Lone Tree Pediatrics and its personnel to deliver medical care to my child listed above.

Please note: Teen drivers receiving certain vaccinations will be asked to stay in our waiting room 15 minutes POST injection for their safety. Please allow for this time in your child's schedule. We are concerned for their safety if they're driving themselves.

____

Parent/Guardian's Name Best number to be reached Alternate number to be reached

____

Parent/Guardian's Name Best number to be reached Alternate number to be reached

PARENTAL/LEGAL GUARDIAN: I acknowledge that I am the above listed child's parent/legal guardian. I have read and fully understand this consent form, and I consent to allow Lone Tree Pediatrics to treat my child listed above. I understand this authorization may be changed at any time by providing a new authorization in writing but is otherwise valid until the minor reaches age 18.

____

PARENT/LEGAL GUARDING SIGNATURE DATE