GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC
CONSENT TO TREATMENT OF A MINOR

In my absence, I authorize GROW Pediatrics and Adolescent Medicine, PLLC and staff to evaluate and treat _____, a minor child, that in his or her judgment, the physician determines advisable for the child's well-being.

Note: If any special parental or custodial relationship exists (such as if the child has one parent only, or if legal custody is held by guardians in the absence of both parents), please explain the situation below, along with your signature, printed name, and a contact phone number.

Parent or Guardian Name _____

Relationship to Patient _____

Parent or Guardian Signature _____ Date _____

Witness Signature _____ Date _____

*Witness Signature _____ Date _____

* *If parent or guardian is giving verbal authorization over the telephone, a second witness should be documented.*