GROW Pediatrics & Adolescent Medicine, PLLC
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CONSENT TO TREATMENT OF A MINOR

APPLICABLE PATIENT(S)

Last Name	First Name	Date of Birth

GENERAL CONSENT

INITIAL
REQUIRED

I authorize GROW Pediatrics and Adolescent Medicine, PLLC and staff to provide reasonable and necessary medical examination, testing, and treatment to my child(ren) that the physician determines advisable for the child(ren)'s well-being.

This authorization has no expiration, and any changes must be made in writing.

TO PERMIT SPECIFIED INDIVIDUALS TO ACCOMANY CHILD(REN)

INITIAL
OPTIONAL

In my absence, I authorize the following individuals to accompany my child(ren) to GROW Pediatrics for the provision of medical services and to view and discuss my child(ren)'s Protected Health Information (PHI).

First and Last Name	Phone Number	Date of Birth	Relationship to Patient	Emergency Contact(✓)

TO PERMIT ONLY PARENT/GUARDIAN TO ACCOMANY CHILD(REN)

INITIAL
OPTIONAL

I DO NOT authorize anyone other that the child(ren)'s father, mother, and/or guardian to accompany my child(ren) to GROW Pediatrics for the provision of medical services.

Please list any explicit limitations/restrictions below:

CONSENT TO TREAT UNACCOMPANIED MINOR (16 years and older)

INITIAL
OPTIONAL

I request and authorize GROW Pediatrics and its staff to provide medical care to my minor child(ren) over the age of 16 years when unaccompanied for routine, preventative, and/or sick visits.

I understand I must have a valid phone number on file in my child(ren)'s chart for verification purposes.

NOTE: Per GROW Pediatrics policy, certain immunizations require the patient to stay in our waiting room 15 minutes POST administration. For their safety, please allow for this time in your child(ren)'s schedule.

SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE

Signature of Patient/Parent/Legal Representative Date

Printed Name of Parent/Legal Representative Relationship to Patient