OFFICE USE ONLY

Patient Number: _____

Date of Birth: _____

Date Notice Received: _____

PEDIATRICS SOUTH

CONSENT FOR TREATMENT IN THE ABSENCE OF A PARENT/GUARDIAN

I hereby give permission and written consent to Pediatrics South, its physicians, employees, agents, and servants to render any and all medical treatment as deemed necessary for my **child listed below**, who is a minor, in my absence.

Patient Name: _____

Select one:

__ This permission applies to **whomever accompanies my child (ren) to the Office.**

__ This permission applies to **only the people who are listed below:**

_____ _____

_____ _____

Parent/Legal Guardian:

Print: _____

Signature: _____ Date: _____