CONSENT TO TREAT MINOR

We require the consent of a parent or legal guardian to provide most types of routine care for patients under the age of 18. **We strongly encourage a parent or legal guardian to attend all well-child visits.** Please sign the first authorization below to allow us to care for your child. If you would like us to care for your child if the child comes in alone or brought in by another person, please sign the second authorization below as well.

Patient Name: _____

1. **Authorization to treat a minor patient when accompanied by a parent or legal guardian**
I am the parent or legal guardian of the patient named above. I authorize and consent to the patient receiving medical care, immunizations or other healthcare treatment as is considered necessary by the clinical staff at Gwinnett Pediatrics and Adolescent Medicine.

Printed name of parent/guardian_____

Signature of parent/guardian: _____

Date: _____

2. **Advance authorization to treat a minor patient when not accompanied by a parent or legal guardian**
I am the parent or legal guardian of the patient named above. I give advance authorization and consent to the patient receiving routine or emergency medical care, immunizations, or other healthcare treatment as is considered necessary by the clinical staff at Gwinnett Pediatrics and Adolescent Medicine. If the patient is being seen for a well check visit or follow-up vaccine visit and is due for vaccines, I understand that the vaccines that are appropriate for the visit will be given per vaccine schedule.

Initial next to the statement(s) you give permission to

_____ I give authorization for my child to be brought in by another family member (Sibling older than 18 yrs., grandparent, aunt, uncle, friend, or another legal guardian).

_____ I give authorization for my teen (15 yr. and older) to either come alone or be accompanied by another legal adult to receive treatment stated above in section 2.

Printed name of parent/guardian: _____

Signature of parent/guardian: _____

Date: _____