Child & Teen Medical Center

Love...Kindness..Excellence

CONSENT FOR MINOR CHILD TO BE SEEN WITHOUT PARENT/LEGAL GUARDIAN

Date:	Patient Name:
Pt DOB:	Parent/Guardian Name:
Contact numbers:	Home:
	Work:
	Cell:

I, _____, mother/father/legal guardian

of_____ give my permission to any provider at Child and Teen Medical Center (CTMC) to see my child without me being present. I consent to the provider performing necessary tests/procedures and or immunizations. This includes taking any necessary steps in events of emergency situations including treatments, medications and transfers of care.

_____

Parent/legal guardian signature

_____

Date

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