Clinical Pediatric Associates of North Texas

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Consent to Treatment of a Minor

Minor's Name: _____ **Date of Birth**: _____

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced Minor ("the minor"), and hereby authorize Clinical Pediatric Associates of North Texas to administer treatment as it so deems necessary to the minor. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian (please spell clearly):

_____ ID _____

Relationship to the minor:
___ Custodial Parent – Mother / Father ___ Guardian by Law-Date Guardianship Commenced _____/_____/_____

Parent/Guardian Date of Birth _____/_____/_____

Address of Parent/Guardian: _____

Home Phone # (_____) _____ Work Phone # (_____) _____

The listed person(s) below has permission to bring the minor & consent to any X-Ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice or any physician or surgeon licensed to practice in the state of Texas, when the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful:

Name _____ Relationship _____ ID _____

Home Phone # (_____) _____ Work Phone # (_____) _____
Address _____ City, State, Zip _____

Name _____ Relationship _____ ID _____

Home Phone # (_____) _____ Work Phone # (_____) _____
Address _____ City, State, Zip _____

Insurance Information
Name of Company _____

Address _____ City, State, Zip _____

Phone _____ Policy Number _____

I would like to request with the Physician/Provider approval that my son/daughter to be seen on follow-up or subsequent visits without parent/guardian attending since he/she is 16 years of age or older and has my permission. _____ Yes _____ No

Signature: _____Date _____/_____/_____ Expiration Date _____/_____/_____

Witness Name: _____

Witness Signature: _____ Date _____/_____/_____