



CONSENT FOR TREATMENT WITHOUT PARENT PRESENT

I give permission for my child to be medically evaluated and treated at Global Pediatrics in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation. I accept responsibility for the physician charges and laboratory fees.

If there are any services that you do not consent to in your absence please list:

My child may be accompanied by:

himself/herself

babysitter

other relationship: _____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

Child's Name

Date

Parent or Guardian Signature

Parent or Guardian Name

Parent or Guardian phone number where they can be reached