CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR

I, _____, the legal guardian of _____,
(Name of Parent or Legal Guardian) (Name of Patient)

date of birth ____/____/_____ (must be over 14years of age), give my permission for my son or daughter to be seen at Bainbridge Pediatrics without my presence.

I hereby request, authorize and direct Bainbridge Pediatrics to examine and treat the minor in my absence. This consent includes, but is not limited to evaluation, care, and treatment from providers working at Bainbridge Pediatrics. I understand such services may include examination, medical treatment, x-ray, laboratory, immunizations and other medical services performed or prescribed. I recognize that by signing this form, I am, as the legal guardian, still responsible for any and all medical expenses incurred at the visits.

I understand that, in certain circumstances, the healthcare providers of Bainbridge Pediatrics may require that a parent or other authorized adult be present with the minor to assist in the diagnosis or treatment process. I agree to cooperate by being present at all times possible and when specifically requested by Bainbridge Pediatrics.

_____

Parent or Legal Guardian Signature Date

_____

Parent or Legal Guardian Name