

Pediatric Associates, P.C.

Fax: 602-371-8929

CONSENT TO TREAT (TODAY ONLY)

Date of Visit: _____

Consent for patients being brought to the office by someone other than the parent or legal guardian:

I, the parent or legal guardian of _____ hereby give
_____ permission to bring my child to the office today for
an examination.

**Please be aware that immunizations and/or procedures cannot be performed
without the parent or legal guardian's verbal consent.**

I will be available to give verbal consent to the administration of immunizations and/or
any procedures at the following phone number(s):

1. (_____) _____
2. (_____) _____

**Consent for a patient who is 16 years of age or older and coming to the office
alone:**

I, the parent or legal guardian of _____ hereby give
Pediatric Associates permission to treat him/her without me being present.

**Please be aware that for your child's safety we will not perform immunizations or
procedures if there is not an adult accompanying the patient.**

I will be available at the following phone number(s):

1. (_____) _____
2. (_____) _____

Parent/Legal Guardian Signature: _____

Date: _____