Pediatric Associates of Franklin

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

Patient Name _____ DOB _____

I give permission to the physicians, providers, and nurses of Pediatric Associates of Franklin to treat my child in my absence. I authorize any medical treatment necessary in my absence and in the event of an emergency for the well-being of the minor mentioned above.

It is understood that this consent is given before any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _____ Relationship to Child: _____ Phone: _____

   Name: _____ Relationship to Child: _____ Phone: _____

   Name: _____ Relationship to Child: _____ Phone: _____

   I give permission for _____ (child's name), who is 16 or older, to be treated unaccompanied. In the event the provider needs to speak with me, I can be reached at (telephone number) _____.

2. Medical concerns: _____
3. Known allergies: _____
4. Medications _____

Name of Parent or Legal Guardian*: _____ Relationship to Child: _____
(Print Name)

Contact Number(s): _____

Address: _____ City, State, Zip: _____

Signature: _____ Date: _____

*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork.

This Consent is effective until withdrawn in writing by the child's parent or guardian or until the child turns 18.