Consent for Treatment of a Minor Child

I, being the parent or guardian of the following patient(s):

Patient Name	**Date of Birth**

do hereby request and authorize **Chapel Hill Pediatrics and Adolescents, PA Physicians and Staff** to perform necessary services for my child(ren) which are deemed advisable by a physician, whether or not I am present at the actual appointment.

Below is a list of individuals (age 18 years or older) who have my permission to bring my child(ren) in for treatment:

☐ Patient(s) by him/herself *if* age 16 years or older (guardian **must** be reachable by phone during time of appointment)

Name	Relationship to Patient	Contact Phone Number

_____ _____

Signature of Parent or Guardian Date

_____

Printed Name of Parent or Guardian

_____ _____

Witness Signature Date