LEITCHFIELD PEDIATRICS

PERMISSION TO TREAT A MINOR WITHOUT THE PRESENCE OF A PARENT/GUARDIAN

Any child under the age of 18 years old cannot be seen by a Leitchfield Pediatrics practitioner or personnel without consent from a parent or legal guardian. If the minor is 16 or 17 years of age, he/she can be seen by themself with your written consent.

Patient's Name: _____ **DOB:** _____

Phone Number for Parents/Guardians _____
Note: you must be available by phone at time of visit.

AUTHORIZATION: I (parent/legal guardian name) _____ request and authorize Leitchfield Pediatrics and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that I am responsible for payment of the patient portion at the time of service. I have the legal right to preauthorize Leitchfield Pediatrics and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations) I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

LIMITATIONS: Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none"):

_____

This consent shall be in effect for: ☐ Date: _____ only ☐ Indefinitely until revoked by written notice

_____
Parent or Legal Guardian Name (please print) Relationship

_____
Parent or Legal Guardian Signature Date