

LAUREL PEDIATRIC AND TEEN MEDICAL CENTER CONSENT TO TREAT
Consent for treatment of a minor

I, _____ being the parent or legal guardian of

Name of the child (children):

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

give my consent and authorize the administration and performance of all treatment and diagnostic procedures, which in the judgment of Laurel Pediatric and Teen Medical Center licensed physicians, nurse practitioner and designees are considered necessary. I am aware that the practice of medicine is not an exact science and that no guarantee can be made concerning the results of treatment. The minor named in this consent form may receive all medical care provided according to **generally and currently accepted standards of pediatric medical care.**

In the absence of the legal guardian the following people are authorized to bring this minor for medical treatment and have access to his/her medical information. (You may name relatives, friends, grandparents, stepparent, non-custodian parent, day care provider, foster parent or others.)

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

If no other person is authorized please circle **None**

Please initial the following:

___ If a minor is brought by any other person not recorded above, Laurel Pediatric and Teen Medical Center will make reasonable to attempts to contact me for verbal consent to treat.

___ If the parent/legal guardian or other authorized person as written above cannot be reached in emergent situation, I consent to Laurel Pediatric and Teen Medical Center to render medical care as deemed necessary.

___ If the custody or guardianship of this minor has changed, I will furnish Laurel Pediatric and Teen Medical Center with the legal forms that are required to be included in the minor's medical record to explain the change in guardianship. This will alleviate any confusion that may occur over who may or may not consent to minor's treatment.

___ I have the right to revoke or change this consent to treat in writing.

Parent/legal guardian signature
Name _____ Relationship _____

Effective Date _____