

Lakeside Pediatrics

Consent for Treatment Form

I, (We) _____, _____
(Parent or Guardian name) (Parent or Guardian Name)

hereby give permission for any and all medical attention to be administered to my child,

Child's Name _____ Date of Birth _____

in the event of accident, injury, sickness, or any other incident requiring medical treatment under the direction of the person(s) listed below.

- I assume the responsibility for the payment of any such treatment.
- I understand that Lakeside Pediatrics is not responsible to contact me if there is an appointment made for my child by one of the person(s) listed below.
- I understand that if I would like to inquire about the appointment I did not attend, it is my responsibility to sign a medical records release to obtain a copy of the medical record.

In the event I am unable to bring my child in for treatment, The Provider may treat my child and prescribe any medications as he/she sees necessary. The following person(s) is designated to act on my behalf:

****Please List Someone other than a parent or guardian** (If there is a step-parent that needs to be added to the chart, we have a separate form for this.**

Name (First and last) _____ Relationship to Patient _____

Name (First and last) _____ Relationship to Patient _____

Name (First and last) _____ Relationship to Patient _____

Name (First and last) _____ Relationship to Patient _____

****If both parents are present today, both signatures are required****

Signature (Parent/Guardian) _____ Date _____

Signature (Parent/Guardian) _____ Date _____

Received by (Lakeside Pediatrics Representative)

Signature _____ Date _____