

**CONSENT FOR TREATMENT BY LEGAL GUARDIAN FOR
MINOR CHILDREN OR INCAPABLE ADULT**

NORTHLAKE CHILDREN'S ASSOCIATES, P.A.

This consent gives us permission to treat the patient for those items specified below. This consent will remain in effect for the duration of the patient care at Northlake Children's Associates or until you notify us otherwise.

As the parent or legal guardian, I _____ give permission for _____ to be seen at Northlake Children's Associates to the guidelines below.

___ May come to the office alone

___ May come to the office with a responsible adult

I give permission for the following:

___ Well child checkups or routine physical exams

___ Immunizations

___ Allergy Shots

___ Sick visits typically covered under a general consent

___ Other:

If additional treatment is needed, I will be contacted to give verbal consent. I can be reached at: Phone # _____ or Phone # _____.

Parent or Legal Guardian Signature

Date

Parent or Legal Guardian Signature

Date

Chart Number(s)