PREMIER pediatrics

Consent for Treatment of a Minor
Without a Parent Present

I give permission for my child to be medically evaluated and treated at Premier Pediatrics of Houston in my absence. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood test) in the course of the evaluation. I accept responsibility for non-covered charges and laboratory fees.
This consent applies to:

- complete physician check-up (including blood and urine samples)
- hearing, vision, scoliosis, and blood pressure screening
- immunizations
- first aid and emergency care
- prescription and treatment for illness
- referrals to an outside agency (for example: hospital, radiology) for services
- not provided at the office

If there are any services that you do not consent to in your absence, please list:
_____

My child will be accompanied by:
[ ] himself/ herself
[ ] babysitter (name)_____
[ ] other (name, relationship)_____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____ _____
Patient's Name Date

_____ _____
Parent or Guardian Signature Parent or Guardian Name

Phone number where parent/guardian can be reached: _____