Consent for Treatment in the Absence of a Parent or Guardian

I give my permission to **Bay Colony Pediatrics**, its physicians, employees, agents, and partners to render any and all medical treatment deemed necessary in my absence to my child(ren) listed below:

_____ _____

_____ _____

_____ _____

Please Select One:

_____ This permission applies to whoever accompanies my child(ren) to the office.

_____ My child (age 16, 17, or 18) has my permission to be seen unaccompanied.

_____ This permission applies only to the people listed below:

_____ _____

_____ _____

Parent/Legal Guardian Signature: _____ Date: _____

If the patient is under 18 years of age, his or her consent is acceptable for these reasons:

_____ Married _____ High School Graduate _____ Pregnancy/Birth