



PEDIATRIC PERMISSION TO TREAT 16 YEAR OLDS AND OLDER

This form is not intended for the use of patients younger than 16 years of age.

I, _____ do hereby grant permission to the providers at Lone Star Pediatrics, to treat my child _____ (Date of Birth: __/__/__) in the event of an emergency or anytime he/she presents to the office requesting medical care.

Sometimes adolescents, 16 years and older, may come to the office alone. If your child may do so, indicate below.

My child may be seen without an adult escort: Yes No

***I also understand, my child may not receive vaccines required for a physical without a parent or a legal guardian present.**

Other people who have permission to bring my child for medical care:

(Must be 18 years or older)

Name and Date of Birth

Relationship

Parent/Legal Guardian Signature Date