Pediatric Associates of Cheshire

435 Highland Ave Suite #110 Cheshire, CT 06410 • (203)-272-0396 • www.pedicheshire.com

CONSENT TO TREAT A MINOR

Date: _____

Patient Information

Name: _____ Date of Birth: _____/____/_____

Name: _____ Date of Birth: _____/____/_____

Name: _____ Date of Birth: _____/____/_____

Name: _____ Date of Birth: _____/____/_____

As an authorized legal guardian of the above named child(ren), I hereby give the following adults permission to accompany and make decisions regarding the necessary treatment of my child(ren) including but not limited to, examinations, injection, immunization and/or diagnostic procedures including laboratory analysis. I understand that only myself and those listed below will have the authority to authorize treatment.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I will notify Pediatric Associates of Cheshire, PC of any changes in the above information.

I have read all the information this sheet and certify that the information I have provided here is true and correct to the best of my knowledge.

Signature of Legal Guardian Date

Printed Name Relationship to Patient