University Place Pediatric Clinic, P.S.

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Advance Consent to Treat Minors

In the event that you are unable to accompany your child to his/her Doctor's appointment, we are required to obtain parental/legal guardian consent prior to treating a child.

I, _____ the parent or legal guardian of _____, authorize and consent to routine and emergency medical treatment for him/her when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

Childs Name:_____
First Middle Last Date of Birth

- Allergies _____

I accept financial responsibility for necessary treatment and services.

_____
Signature of parent/legal guardian Date

_____
Please print name