Consent to Treat a Minor

Child(ren's) Names:

Patient Name: _____Date of Birth: __/__/____

Patient Name: _____Date of Birht: __/__/____

Patient Name: _____Date of Birth: __/__/____

Additional names and birthdates:_____

_____

I, the undersigned, parent(s) or legal guardian of the abovenamed patient, a minor, do hereby authorize the health care providers at Newport Family Practice, PC, to act as agent(s) for the undersigned to consent to physical examination, medical diagnosis and treatment or other medical care which is deemed advisable by, and is to be rendered under the general or special supervision of, the treating primary care provider who is licensed to practice in the state of Pennsylvania, whether such diagnosis or treatment is rendered at the office of said provider or at any hospital. I further acknowledge that I am responsible for any portion of the charges that are not covered by the child's insurance.

In an emergency, it is understood that authorization is granted to the health care providers at Newport Family Practice, PC, in advance of any specific diagnosis, treatment or hospital care rendered to the above named patient. Authorization is granted to provide authority and power on the part of the health care providers to provide all such medical or surgical diagnosis, treatment or hospital care which the aforementioned health care provider(s), in the exercise of his or her best judgment, may deem advisable.

1. Parent or legal guardian signature:
   _____ Date: _____
   Parent printed name: _____

2. Parent or legal guardian signature:
   _____ Date: _____
   Parent printed name: _____

Consent to Treat a Minor accompanied by an Adult other than the Child's Parent or Legal Guardian

Complete this form if you anticipate an adult other than the parent or legal guardian will accompany your minor child(ren) to appointment(s) at Newport Family Practice, PC.

Child(ren's) Names:

Patient Name: _____Date of Birth: __/__/____

Patient Name: _____Date of Birth: __/__/____

Patient Name: _____Date of Birth: __/__/____

Additional names and birthdates:_____

_____

I, the parent or legal guardian of the patient(s) named above, do hereby authorize the health care providers at Newport Family Practice, PC, to perform medical treatment as per the statements above when accompanied by either of the following named adult persons who are at least 18 years of age:

1. Adult's name: (printed name)_____
   Relationship to child:_____
2. Adult's name: (printed name)_____
   Relationship to child:_____
3. Adult's name: (printed name)_____
   Relationship to child:_____

This authorization is valid:

□ **For any and all medical treatment including preventative care, sports/school/well child physicals and vaccinations.**

□ **Today's visit only __/__/____**

□ **For this specific problem(s) (example: allergy injections) OR a specific date range.**

Please specify: _____

This consent will be valid until revoked in writing by me from the date signed unless otherwise specified above in writing.

Parent or legal guardian: (Print Name):_____

Parent or legal guardian (Signature):_____Date:_____

Parent or legal guardian: (Print Name):_____

Parent or legal guardian (Signature):_____Date:_____