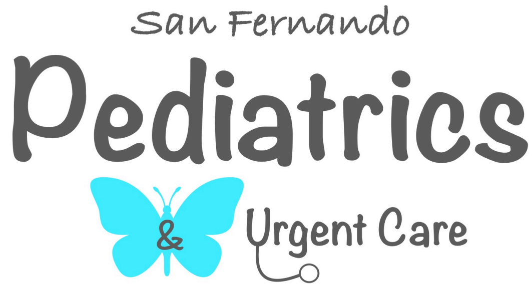

107 N Maclay Ave, San Fernando, CA 91340
Tel: (818) 697-8585 Fax: (888) 799-8585

Consent to treat for minors in the absence of parents

Patient Name: ______________________________________ DOB: ____/____/______

Please sign **ONE** of the options below.

OPTION 1

I authorize San Fernando Pediatrics & Urgent Care' providers to provide medical care for my child. In the event that my child is brought to the clinic by anyone other than a legal guardian or me, **I authorize that my child may be treated in my absence**. I understand that I am responsible for settling any costs arising from this care provided in my absence. The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship

Signature: ___________________________________ Date: ____/____/______

Print Relationship: ____

OPTION 2

I authorize San Fernando Pediatrics & Urgent Care' providers to provide medical care for my child. However, in the event that my child is brought to the clinic by anyone other than a legal guardian or me, **I do not authorize that my child be treated in my absence**. I understand that by signing below, my child will not be treated unless a parent or legal guardian is present.

Signature: ___________________________________ Date: ____/____/______

Print Relationship: ____