Ballentine Pediatrics
Consent for Treatment of a Minor without Parent Present

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Child's Name Date of Birth

Appointment date: ______________________________________

I give permission for my child to be evaluated and treated for medical care at Ballentine Pediatrics in my absence. I understand that it may be necessary to perform diagnostic services such as a strep test or blood work in the course of the evaluation and I accept responsibility for all office charges, laboratory fees and any other services deemed medically necessary for treatment.

This consent applies to:
1. Complete medical check-up (including blood and urine samples)
2. Hearing, vision, scoliosis, and blood pressure screenings
3. Administration of immunizations
4. First aid and emergency care
5. Prescriptions and treatment for illness
6. Referrals to an outside agency for services not provided in our office, such as x-rays.
7: Durable Medical Equipment

If there are any services that you do not consent to in your absence, please specify:

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My child will be accompanied by: ____

Relationship to the patient: ____

By signing this form I agree to the above statements and give permission for Ballentine Pediatrics to share any relevant health information with the person listed on this form.

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Printed Name of Parent/Guardian Relationship Phone #

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Signature Parent/Guardian Date