



**TREATMENT TO MINORS**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_ **Contact Number:** \_\_\_\_\_

Many times, parent(s)/guardian(s) find themselves unable to accompany their minor children to appointments. This form has been prepared for your convenience should you find you are unable to accompany your child.

Choose one of the following options below.

- **I hereby grant Dr. Matheson, Dr. Sartori, Dr. Harris, Dr. Henderson, Dr. Nakamura, and/or Tara Burton, PA-C permission to evaluate and treat my child even though they are unaccompanied on this date of service \_\_\_\_\_ only.**
- **I hereby grant Dr. Matheson, Dr. Sartori, Dr. Harris, Dr. Henderson, Dr. Nakamura, and/or Tara Burton, PA-C permission to evaluate and treat my child even though they are unaccompanied for an extended amount of time not exceeding one year starting on \_\_\_\_\_ and expiring on \_\_\_\_\_.**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**

**I hereby grant permission the person listed below to accompany my child to their appointment and make medical decisions (to include appropriate procedures and treatment) for the child listed above for this date of service \_\_\_\_\_ or for an extended amount of time not exceeding one year starting on \_\_\_\_\_ and expiring on \_\_\_\_\_.**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**