Consent for Treatment without Parent/Guardian Present

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____ Phone: _____

I, _____, hereby voluntarily consent to the rendering of healthcare, including diagnostic testing, examination and/or medical treatment, by the physicians and other designated medical professionals of the Rocky Mountain Pediatric and Respiratory and Allergy Care without me present.

I hereby give consent to the following individuals:

_____ and/or _____
to arrange for any medical care, and to make decisions in my place based on testing deemed to be necessary by the physician and medical team. This may include physical examination, lab work, medication injections/infusions, and/or any other treatment deemed necessary by my child's treating provider. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

His/her address: _____
And his/her telephone number: _____

This consent is in effect for the following (please choose one)

- ☐ Date: _____
- ☐ Date range from: _____ to _____
- ☐ Until I revoke this document (Remainder of the current calendar year)

***Please note Parent or Legal Guardian MUST be present at initial visit.**

_____ _____
Printed Name of Parent or Legal Guardian Relationship to Minor

_____ _____
Parent or Legal Guardian Signature Today's Date