IDEAL PEDIATRIC & ADOLESCENT CARE

121 JPM ROAD
LEWISBURG, PA 17837
TEL: 570-551-0300

CONSENT TO TREAT

PATIENT NAME: _____ DOB: _____

This form give the providers at Ideal Pediatric and Adolescent Care, P.C. permission to provide medical care to your child. It also allows you to designate other family members to bring your child on your behalf.

Option 1
I authorize the care team at Ideal Pediatric and Adolescent Care, P.C. to give medical care to my child.

In the event I cannot bring my child to an appointment, the following persons have my permission to bring my child to the appointment and to authorize any medical care, testing or treatments including any waivers, for my child, on my behalf.

	Name	Relationship to Patient
1.		
2.		
3.		
4.		

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Signature for Option 1:_____
Relationship to Patient:_____

Option 2
I authorize the care team at Ideal Pediatric and Adolescent Care, P.C. to give medical care to my child but I do NOT authorize my child be treated in my absence.

Signature for Option 2: _____
Relationship to Patient:_____

For children over age 16 years, the above patient may be treated without an adult present. Circle one:
YES NO

Signature for patient older than age 16 years: _____
Relationship to Patient: _____