Richmond Pediatrics
357 NW Richmond Beach Road
Shoreline, WA 98177
P: 206.546.2421 F: 206.542.9028

Consent for Treatment of a Minor without Parent or Legal Guardian Present

I give permission for my child to be medically evaluated and treated in my absence by any licensed physician at Richmond Pediatrics. I understand that it may be necessary to perform diagnostic tests *(for example, a throat culture or blood test)* in the course of the evaluation

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

My child/children will be accompanied by:
[ ] babysitter / nanny (name) _____
[ ] other (name, relationship to patient) _____
[ ] other (name, relationship to patient) _____

[ ] My child will be unaccompanied.

Patient name(s)
Name_____ Date of birth_____
Name_____ Date of birth_____
Name_____ Date of birth_____
Name_____ Date of birth_____
Name_____ Date of birth_____

This authorization is valid for the following date(s): Start: _____ End: _____

I accept financial responsibility for physician charges and laboratory fees.

Parent or Guardian signature _____ Today's date_____

Phone number _____

Address _____

Notes:

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