



PERMISSION FOR OUTPATIENT MEDICAL TREATMENT FOR MINORS

Patient _____ Date of Birth _____

I understand that minor patients must be accompanied by an adult for evaluation and treatment at Warwick Pediatrics.

I give permission for _____
Name of adult accompanying the patient

to bring my child for medical care to _____ on _____.
Office Date

By initialing here _____ I also give the person(s) permission to consent to administration of immunizations on my behalf.

This consent is for one time only.

Signature of Parent, Legal Guardian or other Authorized Representative

Date