



## PERMISSION TO ACCOMPANY A MINOR

I \_\_\_\_\_ give permission to \_\_\_\_\_  
(Name of guardian) (Name of adult to be accompanying child)  
to accompany my child \_\_\_\_\_ and authorize treatment for my child in accordance with the office policy of Senders Pediatrics. This includes bringing the child into the office of Senders Pediatrics, providing a history of present illness, disclosure of protected health information, witnessing any physical exam completed by the provider, and responsibility for relaying any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective on: \_\_\_\_\_ and expires \_\_\_\_\_.  
(Today's date) (Date authorization not valid)

\_\_\_\_\_  
(Signature of Parent/Legal Guardian)

**Child's Name:** \_\_\_\_\_

**Child's Date of Birth:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Parent Cell Phone:** \_\_\_\_\_

**Parent Work Phone:** \_\_\_\_\_

### Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency? \_\_\_\_\_

Phone: \_\_\_\_\_

Comments:

### Temporary Guardian Information

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address:

### Health Insurance Information

Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_

ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Copay: \_\_\_\_\_

### Child's Health Information

Current prescribed or over-the-counter medications and dosages:

Allergies, illnesses or other information?