



PERMISSION TO TREAT A MINOR

I _____ give permission to my child _____
(Name of guardian) (Name of child age 16-18 years)

to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Senders Pediatrics. This includes providing a history of present illness, disclosure of protected health information, 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:

Health Insurance Information

No change since last visit (*skip to next section*)

New insurance information listed below:

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?