

Clinical Pediatric Associates of North Texas

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**Consent to  
Treatment of a Minor**

Minor's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced Minor ("the minor"), and hereby authorize Clinical Pediatric Associates of North Texas to administer treatment as it so deems necessary to the minor. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian (please spell clearly):  
\_\_\_\_\_ ID \_\_\_\_\_

Relationship to the minor:  
\_\_\_\_ Custodial Parent – Mother / Father      \_\_\_\_ Guardian by Law-Date Guardianship Commenced \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Date of Birth      \_\_\_\_/\_\_\_\_/\_\_\_\_

Address of Parent/Guardian: \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_      Work Phone # (\_\_\_\_) \_\_\_\_\_

The listed person(s) below has permission to bring the minor & consent to any X-Ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice or any physician or surgeon licensed to practice in the state of Texas, when the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ ID \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ ID \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Insurance Information  
Name of Company \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Policy Number \_\_\_\_\_

I would like to request with the Physician/Provider approval that my son/daughter to be seen on follow-up or subsequent visits without parent/guardian attending since he/she is 16 years of age or older and has my permission.      \_\_\_\_ Yes      \_\_\_\_ No

Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_      Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Witness Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_