Lentz Pediatrics
10777 Hwy 412 W
Lexington, TN 38351

Consent to Treatment of a Child by Authorized Persons

The undersigned parent or legal guardian of _____ authorizes the person(s) listed below to
(Child's Name and date of birth)
consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical

services when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows

the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

   Name: _____Relationship to Child: _____Phone: _____

2. Medical concerns: _____
3. Known allergies: _____

If your child is over the age of 16 and you would like to give permission to treat him/her without the presence of a parent or authorized person(s), please fill out the section below.

I,_____, hereby authorize Lentz Pediatrics to treat _____, who is over the age of 16, without a parent or authorized person(s)

Signature: _____ Relationship to Child:_____Date**:** _____

This consent is to be filled out by parent or legal guardian.
This consent is effective until withdrawn in writing by the child's parent or guardian.