

Lentz Pediatrics  
10777 Hwy 412 W      19 Security Drive  
Lexington, TN 38351      Jackson, TN 38305

**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) (someone other than parent/guardian):

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Medical concerns: \_\_\_\_\_

3. Known allergies: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Date: \_\_\_\_\_

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)

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This consent is effective until withdrawn in writing by the child's parent or guardian.