LENTZ PEDIATRICS

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Lexington, TN 38351
Phone 731-968-5558
Fax 731-968-5567

19 Security Drive
Jackson, TN 38305
Phone 731-664-9040
Fax 731-664-9041

Consent to Treat Minor

The undersigned parent or legal guardian of _____ authorizes the person(s) listed
(Child's Name & DOB)
below to consent to treatment of the child, including, but not limited to routine care, sick visits, and emergency medical treatment in your absence.

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.

Do you give permission for your child to receive recommended vaccinations when parent/guardian is not available in person? ☐ Yes ☐ No

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).

Parent/Guardian Signature: _____ Date: _____

This consent is effective until withdrawn in writing by the child's parent or guardian.