Parental Consent to Treat for Minor or Incapable Adults

Signing this form gives Pageland Family Medicine permission to treat the patient indicated for items specified below. This consent form will be valid for one (1) year, or until our practice is notified otherwise.

As the parent or legal guardian, I _____________________________ (your name),
give permission for _____________________________ (patient’s name) to be seen at Pageland Family Medicine according to the guidelines below.

☐ May visit the physician’s office alone
☐ May visit the Physician’s office with a responsible adult

I give permission for the following:

☐ Well child checks or routine physical examinations
☐ Immunizations
☐ Adult or
☐ Pediatric Immunizations information packet given to parent/legal guardian and questions answered _______________________________ (staff signature)

☐ Allergy Shots
☐ Sick visits (typically covered under a general consent)
☐ Other: ___________________________________________________________________

If additional treatment is needed, I am to be contacted to give verbal consent. I can be reached at: ______________________ (phone or pager number) or ______________________ (phone or pager number).

Parent/Legal Guardian Signature _____________________________ Date: __________

Witness Signature: _____________________________ Date: __________