Carolinas HealthCare System

Providence Pediatrics

This consent gives us permission to treat the patient for those items specified below. This consent form will remain in effect for one year, or until you notify us otherwise.

As the parent or legal guardian, I _____ (your name),

give permission for _____ (patient's name), to be seen at Providence Pediatrics according to the guidelines below.

- ☐ May come to the Doctor's office alone
- ☐ May come to the Doctor's office with a responsible adult: 1. _____
  2. _____
  3. _____

I give my permission for the following:

- ☐ Well child checks or routine physical examinations
- ☐ Immunizations
  - ☐ Pediatric immunization information packet given to parent/legal guardian and questions answered _____ (staff signature)
- ☐ Sick visits typically covered under a general consent
- ☐ Other: _____

If additional treatment is needed, I will be contacted to give verbal consent.

I can be reached at: _____ (phone or pager number) or

_____ (phone or pager number).

Parent or Legal Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____