Physicians' Primary Care

Consent for Treatment of a Minor without Parent Present:

I give permission for my child to be medically evaluated and treated at Physicians' Primary Care of SWFL in my absence. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood test) in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

This consent applies to:

1. Complete physician check-up (including blood and urine samples)
2. Hearing, vision, scoliosis and blood pressure screening
3. Immunizations
4. First aid and emergency care
5. Prescription and treatment for illness
6. Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

If there are any services that you do not consent to in your absence, please list:

_____

_____

My child will be accompanied by:
[ ] himself/herself

[ ] babysitter (name) _____

[ ] other (name, relationship) _____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____ _____
Child's Name Date

_____ _____
Parent or Guardian Signature Parent or Guardian Name

_____ _____
Phone number where parent or guardian can be reached Employee Initial

******This form is only authorized for 1 year from the date above. ******