Consent for Treatment of a Minor Child
Family Form

I, being the parent or guardian of the following patient(s):

Patient Name	Date of Birth

do hereby request and authorize **Chapel Hill Pediatrics and Adolescents, PA Physicians and Staff** to perform necessary services for my child(ren) which are deemed advisable by the physician, whether or not I am present at the actual appointment.

Below is a list of individuals who have my permission to bring my child(ren) in for treatment:

☐ Patient(s) by him/herself ***if*** age 16 years or older.

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Signature of Parent or Guardian Date

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Printed Name of Parent or Guardian

_____ _____

Witness Signature Date

****Consent in effect until changed****