Consent to Medical Treatment of Minors

**I hereby give consent to Kinder Haus Pediatrics physician and staff to perform medical treatment to include medical examinations, lab testing and treatment to include medications or vaccinations as deemed advisable by a licensed physician.
**I understand that this authorization is given in advance of any specific diagnosis, treatment, or medical care being required.

Name of Minor Child	DOB	Driving age minor (>age 16y) can be treated without guardian YES or NO

**I hereby authorize the following person(s) to act on my behalf to consent to medical treatment for above minors.

Name	Relationship to patient	Phone #	Allowed to give consent for vaccinations YES or NO

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed: _____

Print Name: _____ Date: _____

Please specify relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody