FOREST HILLS
PEDIATRIC ASSOCIATES

Consent to Treat Unaccompanied Minor

Patient's Name:_____ DOB:_____

DATE OF VISIT: _____

I, _____, as a parent or legal guardian of the child listed above, grant my child permission to be unaccompanied at a visit for the following problem:

_____

_____

I will expect that my child will update me on what transpired at the visit and a record of the visit will be available via the Patient Portal within 48 hours. If any other non-emergent issues arise, they will not be addressed and a future visit will need to be scheduled under the direction of a parent.

You may reach me at the following number _____.

Preferred Pharmacy: _____

Signature: _____ Date:_____

This authorization is ONLY good for the above problem on the date of the visit.