BETHESDA PEDIATRICS

CONSENT FOR TREATMENT OF A MINOR

Patients under the age of 18 are required by Maryland law to have consent from a parent or legal guardian before receiving any medical care from Bethesda Pediatrics, except in emergency circumstances.

Patient name: _____ Date of birth: _____
Appointment date: _____

Allergies: _____
Current medications: _____
Chronic conditions: _____

Please initial to give consent:

_____ for minor to be seen independently *without* an accompanying adult
_____ for minor to be seen *with* an accompanying adult, who is not a parent or legal guardian, that is authorized to make medical decisions

Please initial to indicate services authorized:

_____ evaluate and treat for illness, including any relevant lab tests
_____ full physical exam with any recommended vaccines and lab tests
_____ administer vaccine(s). Name of vaccine(s): _____
_____ lab test(s). Name of test(s): _____

Please indicate any SPECIFIC LIMITATIONS on the services authorized:

_____
_____
_____

I (parent or legal guardian name) _____ authorize Bethesda Pediatrics to render services as indicated above. I also acknowledge that any applicable copayment or charges are due at the time of service.

Signature of parent or legal guardian: _____
Date: _____

For office use only:
I (name of Bethesda Pediatrics staff) _____ completed the form above and obtained consent verbally.

Signature of staff: _____
Date: _____