

Gales Ferry Pediatric Group

1527 Route 12  
Gales Ferry, CT 06335

633 Middlesex Tpke.  
Old Saybrook, CT 06475

Consent for Treatment of Minors

Purpose: This form may be used to allow minors of legal driving age (16 or older) to receive routine care and services at the Gales Ferry Pediatric Group without a parent or proxy present.

For some families, it may be more convenient to have prior authorization in place that allows routine medical care to be delivered to minors if a parent or legal guardian cannot be present to provide consent. If you would like to have such a preauthorization in place, please review and complete the following form authorizing treatment for your minor child (age 16 or older) in advance.

AUTHORIZATION:

I have the legal right to preauthorize the Gales Ferry Pediatric Group and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation and advice, physical exam, administration of immunizations, allergy injections, lab work (examples include: throat or nasal swabs, blood draws, urine collection, wart treatment with liquid nitrogen, debridement of minor burns, incision and drainage of abscesses, and handling of prescriptions.

I request and authorize the Gales Ferry Pediatric Group and its personnel to deliver routine medical care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child.

Patient Name: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. If none, please state "NONE".

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Parental contact information for questions regarding treatment of the minor child:

Parent's Name: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_  
Evening Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

Parent's Name: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_  
Evening Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

I hereby indemnify and hold harmless Gales Ferry Pediatric Group and all their officers, agents and employees from any liability for acting in reliance on this authorization. This authorization is valid following the date signed below unless withdrawn in writing. Only one parent's signature is required.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date