Agave Pediatrics
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Consent For Treatment of a Minor Child

Date of Birth_____/_____/_____

I, the undersigned, parent/guardian of _____, a minor, do hereby authorize and direct Agave Pediatrics to provide ongoing routine and emergency health care.

Initials: _____

Consent from Parents or Guardians for Authorized Persons

As the biological parent or step parent/guardian (court papers necessary) of _____, I am granting permission for the below listed person(s) to bring my child in for treatment and/or care.

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

_____ **Initials** - I am granting full permissions, meaning the below listed person(s) will be allowed to agree to treatments, and know all health history pertaining to my child.

_____ **Initials -** I am granting permissions, meaning the below listed person(s) is only allowed to bring my child in, and will have access to all health history, but not allowed to agree to treatments without my direct consent.

_____ **Initials** - I am granting limited permissions, meaning the below listed person(s) is allowed to bring my child in to the office, but is not allowed access to any medical information or treatment of my child. I will be informed of the visit results, and I will be notified prior to any treatment for my child.

IF YOU DO NOT HAVE ANYONE LISTED BELOW, NO ONE BUT THE PARENT/LEGAL GUARDIAN WHO HAS FILLED OUT THIS REGISTRATION WILL BE ALLOWED TO BRING PATIENT TO APPOINTMENTS INCLUDING OTHER PARENT, STEP PARENTS, GRANDPARENTS, ETC.

Please list person(s) here _____ Relationship to patient: _____

_____ Relationship to patient: _____

_____ Relationship to patient: _____

_____ Relationship to patient: _____

_____ Relationship to patient: _____

_____ Relationship to patient: _____

_____ _____
Patient Name Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Legal Guardian Date

YOU MUST INCLUDE A COPY OF YOUR DRIVERS LICENSE WHEN RETURNING THIS FORM FOR IT TO BE VALID - THANK YOU!