

PEDIATRICS WEST
PARENTAL CONSENT FOR MEDICAL CARE FOR UNDERAGE PATIENTS

Massachusetts law requires parental consent for medical, surgical, and psychiatric treatment of minors. *IN MASSACHUSETTS, MINORS ARE INDIVIDUALS UNDER 18 YEARS OF AGE.*

Pediatrics West encourages you to accompany your child to his/her appointments. However, on those rare occasions when you cannot, we must have your consent to see and treat your child in your absence.

Please complete this Consent to Medical Treatment and have your child bring it with him/her to the appointment, or fax it to our office prior to the appointment at _____.

CONSENT TO MEDICAL TREATMENT

Patient Name: _____

Patient Address: _____

Patient Date of Birth: _____

Appointment Date: _____

I, (name) _____, am the parent or legal guardian of the minor student above.

I hereby authorize Pediatrics West to see and treat my son or daughter, indicated above, on the appointment date set forth above, and consent to the performance of medical treatment by Pediatrics West for my son or daughter during said appointment.

Parent/Legal Guardian Name and Address:

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Parent/legal guardian signature

Date _____