Hunterdon Health
Hunterdon Pediatric Associates

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Consent for Medical Treatment

I/We, _____

the parent(s)_____ legal guardian(s)_____

Name of Patient:_____ DOB: _____
authorize the following individuals to accompany and consent to treatment, procedures, and immunizations for the forgoing child in my/our absence.

(PLEASE LIST ANYONE OTHER THAN THE PARENT WHO IS OVER 18)

1._____ _____
(Name) (relationship to patient)

2._____ _____
(Name) (relationship to patient)

3._____ _____
(Name) (relationship to patient)

4._____ _____
(Name) (relationship to patient)

Signature:_____ (Date) _____

Witness:_____ (Date) _____

Update required annually:

Date:_____ Signature:_____Witness:_____

Date:_____ Signature:_____Witness:_____

Date:_____Signature:_____Witness:_____

Date:_____Signature:_____Witness:_____

Date:_____Signature:_____Witness:_____