CONSENT FOR TREATMENT OF MINOR CHILD

Patient for whom consent is given:

_____ _____

Full Legal Name Birth Date

As the parent or legal guardian of the minor child listed above, I hereby consent to any radiology or lab testing, medical or surgical treatment, or other clinical service rendered to the child under the care of any qualified physician, as well as any assistant, designee, or employee on the staff of Kids Plus Pediatrics.

My consent is given in advance of a specific medical diagnosis or treatment that may be required, and is given to encourage each physician, as well as any assistant, designee, or employee of Kids Plus Pediatrics, to exercise his/her best judgment in ordering tests or treatments appropriate to the child's medical needs.

The consent is effective on the date below, and will be updated if the medical history or information of the child, or of the parent/legal guardian, changes.

_____ _____

Signature of Parent/Legal Guardian Relationship to Child

_____ _____

Witness Effective Date