MUNSON HEALTHCARE
OMH Medical Group
A Service of Otsego Memorial Hospital

PEDIATRIC CONSENT FORM

This consent may be utilized if a parent/guardian is not present at the time of medical treatment.

RCHILD'S NAME: _____ **DOB:** _____

I (We) the parent (s) or legal guardian (s) authorize the individual (s) named below to act in my (our) behalf with the full authority to grant permission for any medical treatment, including administration of immunizations, or a surgical or office procedure that is in the best interest of the above named child, in the opinion of the OMH providers. I understand that the provider may request to contact the parent/guardian prior to providing medical treatment even though this consent is presented. Since medicine and surgery are not an exact science, it is acknowledged that no results can be guaranteed. I understand that as parent(s) or legal guardian(s) that I am financially responsible for all care received as a result of this consent, including services provided by Otsego Memorial Hospital, such as diagnostic testing.

ADULTS THAT MAY SIGN FOR MEDICAL TREATMENT IN MY (OUR) ABSENCE:
(Authorized individuals should also be listed in Privacy Practices)

Name:_____ Phone # : _____

Address: _____

Name:_____ Phone # : _____

Address: _____

Name:_____ Phone # : _____

Address: _____

This consent form will be in effect for 12 months from signing or less time if specified: _____

AUTHORIZED BY: ***(Both parents signature preferred, but not required)***

By signing below, I certify that I am the legal parent or guardian of the child identified above and am acting within my authority in signing this Pediatric Consent form.

□ **Mother** *(Printed)* *or* □ **Legal guardian** *(Printed):* _____

Signature:_____ Date: _____ Witness:_____

Renewal Signature: _____ Date: _____ Witness:_____

□ **Father** *(Printed)* *or* □ **Legal guardian** *(Printed):* _____

Signature:_____ Date: _____ Witness:_____

Renewal Signature: _____ Date: _____ Witness:_____

ANY CHANGES TO THIS CONSENT MUST BE MADE IN PERSON AT THE PHYSICIANS OFFICE.