OLYMPIA PEDIATRICS, PLLC.

Parental Advance Consent to Treat Minors

In the event that you are unable to accompany your child to their doctor's appointment, we are required to obtain parental consent prior to treating a child. When parents are not immediately available, this can take time and delay treatment.

This is to certify that the person(s) listed below has my permission to authorize necessary medical care for my child. This authorization will be in effect until revoked in writing by me. I accept financial responsibility for necessary treatment and services.

Child's First Name _____ MI ____ Last Name _____ DOB _____

Other children covered under this authorization:

Child 1: First Name _____ MI ____ Last Name _____ DOB _____
Child 2: First Name _____ MI ____ Last Name _____ DOB _____
Child 3: First Name _____ MI ____ Last Name _____ DOB _____
Child 4: First Name _____ MI ____ Last Name _____ DOB _____

Person(s) (NOT parent) authorized to seek medical care for the above mentioned child(ren)

Name	Relationship to Patient	Phone Number	
_____	_____	_____	☐ Check to list this person as a family emergency contact in chart
_____	_____	_____	☐ Emergency contact
_____	_____	_____	☐ Emergency contact
_____	_____	_____	☐ Emergency contact