Bright Oaks Pediatric Center
2111 Laurel Bush Road, Suite H
Bel Air, MD 21015
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(410) 569-3300
(410) 569-8199 (fax)

Consent for Treatment of a Minor

I, _____

being the parent or legal guardian of

_____ ,
(Child's Name)

give my consent and authorize the administration and performance of all treatment and diagnostic procedures, including laboratory tests, which in the judgment of Bright Oaks Pediatric Center, LLC's licensed physicians, nurse practitioners and designees are considered necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor named in this Consent may receive all medical care provided according to generally and currently accepted standards of pediatric care.

Please list Parent(s)/Legal Guardian(s)

Parent/Legal Guardian Name: _____ Relationship to minor: _____
Parent/Legal Guardian Name: _____ Relationship to minor: _____

In the absence of the parent/legal guardian, the following people are authorized to bring this minor for medical treatment and have access to his/her medical information (You may name relatives, friends, grandparents, stepparents, non-custodial parent, daycare providers, foster parents or others.)

Name: _____ Relationship to minor: _____
Name: _____ Relationship to minor: _____
Name: _____ Relationship to minor: _____
Name: _____ Relationship to minor: _____

If no other person is authorized, please write NONE: _____

Please initial the following:

_____ If a minor is brought by any other person not recorded above, Bright Oaks Pediatric Center, LLC will make reasonable attempts to contact Parent/Guardian for **verbal consent** to treat.

_____ I understand that consent from the parent(s)/legal guardian(s) or authorized person(s) named above, is required for all **non-emergent** situations.

_____ If the parent(s)/legal guardian(s) or authorized person (s) named above cannot be reached in an **emergent situation**, I consent to Bright Oaks Pediatric Center, LLC to render medical care as **deemed necessary**.

_____ I have the right to revoke or change this consent to treat in writing.

_____ If the custody or guardianship of this minor has changed, I will furnish Bright Oaks Pediatric Center, LLC with the legal forms that are required to be included in the minor's medical record to explain the change. This will alleviate any confusion that may occur over who may or may not consent to minor's treatment.

Parent/Legal Guardian Signature _____
Parent/Legal Guardian Printed Name _____
Date of Consent: _____