SOUND BEACH
PEDIATRICS
41° 02' 56"N | 73° 33' 50"W

Consent to Treat Minor

Patient Name: _____ DOB: _____

I hereby give consent to Sound Beach Pediatrics to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care for my child, as deemed advisable by a licensed physician as well as any assistant on the staff of Sound Beach Pediatrics.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required.

This consent is given to any and all such diagnoses, treatments and hospital care which a licensed physician at Sound Beach Pediatrics recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian. ***Consent solely applies when person(s) identified below is(are) accompanying my child.****

Signed: _____
Printed Name: _____
Address: _____
Telephone: _____

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

Date: _____

Please specify your relationship to minor:

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

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