



Indian Trail Pediatrics

Carolinas HealthCare System

Parental Consent to Treat for Minor or Incapable Adults

Signing this form gives Indian Trail Pediatrics permission to treat the patient indicated for items specified below. This consent form will be valid for one (1) year, or until our practice is notified otherwise.

As the parent or legal guardian, I _____ (your name),
give permission for _____ (patient's name) to be seen at

Indian Trail Pediatrics according to the guidelines below.

- May visit the physician's office alone
- May visit the Physician's office with a responsible adult

I give permission for the following"

- Well child checks or routine physical examinations
- Immunizations
- ~~Adult or~~
- Pediatric Immunizations information packet given to parent/legal guardian and questions answered _____ (staff signature)
- ~~Allergy Shots~~
- Sick visits (typically covered under a general consent)
- Other: _____

If additional treatment is needed, I am to be contacted to give verbal consent.

I can be reached at: _____ (phone or pager number) or
_____ (phone or pager number).

Parent/Legal Guardian Signature _____ Date: _____

Witness Signature: _____ Date: _____