Use this form to list any person(s) that have your permission to bring your child/children to our office for treatment in the event that the parent(s) or legal guardian(s) are not available.

Modesto Pediatrics

Dena Lenser, M.D. – Ann Marie Truscello, M.D.
3109 Coffee Road, Suite A
Modesto, CA 95355
(209) 522-0001 - (209) 549-7077-fax

Consent to Treat a Minor

I (we) the undersigned parent(s) or legal guardian of: _____
(Child/Children's Name)

a minor, do hereby authorize _____
(i.e. name of relative, babysitter, friend, etc.)

as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis, or treatment, or hospital care, which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act or the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that the authorization is given in advance of any specific diagnosis, treatment, of hospital care, being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care, which the aforementioned physician in the exercise of his/her best judgment may deem advisable.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

Effective Date: _____

Signature of Parent(s) or Legal Guardian(s): _____

_____

Signature of Witness: _____