



Arboretum Pediatrics
Carolinas HealthCare System

Parental Consent to Treat for Minor or Incapable Adults

Signing this form gives Arboretum 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
Arboretum Pediatrics according to the guidelines below:

- May visit the physicians' office alone
- May visit the physicians' office with a responsible adult

Please specify: _____

I give permission for the following:

- Well child checks or routine physical examinations
- Immunizations
- Adult or
- 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: _____