CONSENT FOR TREATMENT OF MINOR CHILD

Patient for whom consent is given:

_____ _____

Patient Legal Name Date of Birth

As the parent(s) of the minor child listed above, I(we) hereby consent to any radiology or lab testing, medical or surgical treatment, or other medical service rendered to my (our) minor child under the care of any qualified physician, as well as any assistant, designee, or employee on the staff of Bay Colony Pediatrics.

My (our) consent is given in advance of a specific medical diagnosis or treatment that may be required, and is given to encourage each physician as well any assistant, designee, or employee of Bay Colony Pediatrics to exercise his/her best judgment in ordering tests or treatment appropriate to the child's medical needs.

This consent is effective on the date below and will be updated if the medical history or information of the child or parent(s) changes.

_____ _____

Signature of Parent Effective Date

_____ _____

Signature of Parent Effective Date