# PARENT/GUARDIAN CONSENT

**PARENT/GUARDIAN CONSENT**

Please READ CAREFULLY and sign and Date Below

**I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY PEDIATRIC ASSOCIATES OF WATERTOWN, PC OF ANY AND ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AND TO PROVIDE THE OFFICE WITH INFORMATION IF THERE ARE ANY CUSTODY RESTRICTIONS INVOLVING MY CHILD.**

LAST NAME OF PATIENT FIRST MIDDLE DATE OF BIRTH

SOCIAL SECURITY NUMBER COURT ORDER ON FILE

MAILING ADDRESS CITY STATE ZIP

**THE PERSONS LISTED ARE THE ONLY ONES WHO MAY BE ALLOWED TO SEEK MEDICAL CARE AND/OR TREATMENT FOR MY CHILD AT PEDIATRIC ASSOCIATES OF WATERTOWN. I ALSO UNDERSTAND A PHOTO ID OF THE INDIVIDUALS WILL BE REQUIRED AT EACH VISIT AND A COPY WILL BE MADE AND PLACED IN MY CHILD'S CHART.** PLEASE NOTE: ANYONE YOU ARE GRANTING PERMISSION TO MUST BE OVER THE AGE OF 18.

FATHER'S NAME PREFERRED PHONE (CELL/HOME) MOTHER'S NAME PREFERRED PHONE (CELL/HOME)

CHILD LIVES WITH ADDRESS RELATIONSHIP TO CHILD

OTHER PERSONS THAT YOU CONSENT TO BRING YOUR CHILD/CHILDREN IN (MUST BE 18 YEARS OF AGE OR OLDER):

OTHER (NAME) PREFERRED PHONE (CELL/HOME) RELATIONSHIP TO CHILD

OTHER (NAME) PREFERRED PHONE (CELL/HOME) RELATIONSHIP TO CHILD

OTHER (NAME) PREFERRED PHONE (CELL/HOME) RELATIONSHIP TO CHILD

OTHER (NAME) PREFERRED PHONE (CELL/HOME) RELATIONSHIP TO CHILD

IN CASE OF AN INCIDENT WHERE I AM NOT ABLE TO BRING MY CHILD FOR HIS/HER APPOINTMENT, OR IF EMERGENCY TREATMENT IS REQUIRED, I UNDERSTAND THAT ONE OF THE PERSONS LISTED ABOVE ON THIS FORM WILL BE ALLOWED TO ARRANGE AND SEEK TREATMENT FOR MY CHILD.

BY SIGNING BELOW, I AM AWARE THAT IT IS SOLELY MY RESPONSIBILITY TO NOTIFY PEDIATRIC ASSOCIATES OF WATERTOWN, PC OF ANY/ALL CHANGES IN THE INFORMATION RECORDED ON THIS FORM AS WELL AS ALL FINANCIAL RESPONSIBILITIES AND TO PROVIDE THE OFFICE WITH ANY AND ALL CUSTODY RESTRICTIONS INVOLVING MY CHILD.

PRINT PARENT/GUARDIAN NAME RELATIONSHIP TO PATIENT

PARENT/GUARDIAN SIGNATURE DATE