BLACK HILLS PEDIATRICS, L.L.P.
MEDICAL CONSENT FORM FOR TREATMENT OF MINOR

_____ _____
PATIENT/CHILD NAME **DATE OF BIRTH**

▶ABSENT PARENT/LEGAL GUARDIAN◀

Failure to have consent on file except in emergency situations may delay treatment while we attempt to obtain your consent.

I hereby authorize the following people listed below to obtain medical care, including hospitalization, for my child during my absence: **day care providers, relatives, friends, step-parents.**

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

3. Name: _____ Relationship: _____

4. Name: _____ Relationship: _____

I, the undersigned, as the parent or legal guardian hereby authorize such diagnostic, medical, and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and Black Hills Pediatrics, L.L.P., and its employees shall not be responsible in any way for the consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery in so far as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

This consent expires in 1 year unless revoked in writing. As parent/legal guardian, I give consent for the emergency contacts shown above to act on my behalf until I am available. I will be responsible for all charges not covered by insurance.

_____ _____
Signature of Parent or Legal Guardian **Date**

_____ _____
Printed Name **Relationship**

Revised 4/1/14