MRN ____________________

Date____________________

Casas Adobes Pediatrics

PERMISSION TO TREAT

Patient Name________________________________ DOB____________________

I grant permission to Casas Adobes Pediatrics to treat my child for medical care.

My child of 16 years and older, may be seen without an adult chaperon:
☐ Yes ☐ No

I am aware for my child's first appointment a legal guardian must be present. However after the initial appointment my child may be brought in for care by:

Name	Relationship
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

____________________ ____________________
Parent/Guardian Signature Date