eden park
pediatric associates

Consent for Treatment in the Absence of a Parent or Guardian

I give my permission to **Eden Park Pediatric Associates**, its physicians, employees, agents, and partners to render any and all medical treatment deemed necessary in my absence to my child(ren) listed below:

Child's Name	Date of Birth

Please select one:

_____ This permission applies to whomever accompanies my child(ren) to the office.

_____ My child (age 16, 17, or 18) has my permission to be seen unaccompanied.

_____ This permission applies only to the people listed below:

Name	Relationship

Parent/Legal Guardian Signature: _____ Date: _____