CONSENT TO TREAT MINOR

I hereby give consent to Caritas Pediatrics and Wellness to perform any lab or radiology testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician as well as any assistant on the staff of Caritas Pediatrics and Wellness to my dependents as listed in this registration packet. I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. This consent is given to any and all such diagnoses, treatments, and hospital care which a licensed physician at Caritas Pediatrics and Wellness recommends.

AUTHORIZATION FOR NON-PARENT CONSENT TO CARE

Name	Relationship to Patient(s)	Phone Number

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed:_____Date:_____

Printed Name:_____