Aquarius Pediatrics
Growing Happy Families

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Consent To Treat Minor

I hereby give consent to Aquarius Pediatrics to perform any radiology or lab testing, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care as deemed advisable by a licensed physician, as well as any medical assistant or nurse practitioner on the staff of Aquarius Pediatrics to the minor(s) named below.

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 Aquarius Pediatrics recommends.

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

Minor #1: Name _____ Date of Birth _____

Minor #2: Name _____ Date of Birth _____

Minor #3: Name _____ Date of Birth _____

Print Name: _____

Siganture: _____

Date: _____

Please specify relationship to minor, circle one:

Parent with legal custody Guardian with legal custody