

# Salud Pediatrics

Office: 847-854-9402  
Fax: 847-854-9403

## CONSENT TO TREAT (TODAY ONLY)

Date of Visit: \_\_\_\_\_

Consent for patients being brought to the office by someone other than the parent or legal guardian:

I, the parent or legal guardian of \_\_\_\_\_ hereby give \_\_\_\_\_ permission to bring my child to the office today for an examination.

Please be aware that immunizations and/or procedures cannot be performed without the parent or legal guardian's verbal consent.

I will be available to give verbal consent to the administration of immunizations and/or any procedures at the following phone number(s):

1. (\_\_\_\_\_) \_\_\_\_\_
2. (\_\_\_\_\_) \_\_\_\_\_

Consent for a patient who is 16 years of age or older and coming to the office alone:

I, the parent or legal guardian of \_\_\_\_\_ hereby give Dr. Betancourt and/or Dr. Chandran permission to treat him/her without me being present.

Please be aware that for your child's safety we will not perform immunizations or procedures if there is not an adult accompanying the patient.

I will be available at the following phone number(s):

1. (\_\_\_\_\_) \_\_\_\_\_
2. (\_\_\_\_\_) \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_