Westchester Park Pediatrics PLLC

For Children Under Age 18

I authorize my child _____, Date of Birth _____

to be seen on _____(date) by Westchester Park Pediatrics

1. Alone of Accompanied to Appointment:

___ My child may be seen without being accompanied by anyone.

___ My child may be seen only accompanied by _____ and CWPW personnel.

2. Alone or Accompanied in Examination Room:

___ My child may be seen and treated in the examination room without being accompanied by anyone.

___ My child may be seen and treated in the examination room only accompanied by _____ and CWPW personnel.

___ I authorize any test, procedure, and/or vaccination to be done on my child in the course of treatment.

3. This authorization is valid for the following date or period of time _____.

Date _____ Parent/Guardian Signature _____

Print Name _____

FOR VERBAL CONSENT OBTAIN ANSWERS TO #1, #2, AND #3 ABOVE.

Date _____ Verbal consent obtained by phone call at: _____

Phone number received from or called and time of call: _____

Name of person giving verbal consent and relationship to patient: _____

_____ Witnessed by: _____