Cereal City Pediatrics
there as they grow

4520 Beckley Road
Battle Creek, MI 49015
Call: 269.969.8723
Fax: 269.969.8724

PERMISSION TO ACCOMPANY A MINOR WITHOUT THE PRESENCE OF A PARENT/GUARDIAN

By law, any child under the age of 18 years old cannot be seen by a doctor without written consent from a parent/guardian or without an adult present. If the minor is under 16, he/she must be accompanied by an adult. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: _____ **DOB:** _____

For those occasions when you may not be with your child, please list those individual(s) age 18 or older who may give us consent for care:

_____ _____

Name Phone Relationship to Patient

_____ _____

Name Phone Relationship to Patient

Child's Health Information:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Allergies, illnesses or other comments: _____

Health Insurance Information ☐ No change since last visit (skip to next section)
Insurance Company: _____ Policy Holder: _____
ID Number: _____ Group Number: _____
Effective Date: _____ Copay: _____

Authorization: I (parent/legal guardian name) _____ request and authorize Cereal City Pediatrics and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that I am responsible for payment of the patient portion at the time of service. I have the legal right to preauthorize Cereal City Pediatrics and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations) I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

Limitations: Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none"): _____

Phone # for Parents/Guardians – Should the provider have questions please be available by phone: _____

This consent shall be in effect for Date: _____**(only)** **Indefinitely, until revoked by written notice.**

_____

Parent or Legal Guardian (please print) Relationship

_____

Parent or Legal Guardian Signature Date