CONSENT FOR TREATMENT

CONSENT FOR TREATMENT IN THE ABSENCE OF A PARENT OR GUARDIAN

I GIVE MY PERMISSION AND WRITTEN CONSENT TO **PADDER HEALTH SERVICES**, ITS PHYSICIANS, EMPLOYEES, AGENTS, AND PARTERS TO RENDER ANY AND ALL MEDICAL TREATMENT DEEMED NECESSARY TO MY CHILD (REN) LISTED BELOW IN MY ABSENCE.

_____

_____

_____

PLEASE SELECT ONE:

_____ This permission applies to whomever accompanies my child(ren) to the office.

_____ My child (age 16, 17, or 18) has my permission to be seen unaccompanied.

_____ This permission applies only to the people listed below:

_____

_____

_____

PARENT / LEGAL GUARDIAN SIGNATURE: _____ **DATE:** _____

If the patient is under 18 years of age, his or her consent is acceptable for these reasons:

_____ Married _____ High School Graduate _____ Pregnancy/Birth