NorthShore
University HealthSystem
Medical Group

Pediatric Endocrinology

Phone (847) 663-8508
Fax (847) 663-8506

Parent/Guardian Consent for Treatment of Unaccompanied Minor

Date:____________________

Patient Name:____

At times parents will send their children who ae old enough to drive to our office without the parent of legal guardian present. If your child does drive and will be coming to our office independently, please sign the consent below.

Failure to have consent on file except in emergency situations may delay treatment while we attempt to obtain your consent.

I, ______________________________(please print) the parent/legal guardian hereby authorize diagnostic, medical and or surgical treatment of my child (not including vaccines*) which may be considered necessary or appropriate under the circumstances for the treatment of any illness and injury of my child.

*Vaccines require written or verbal consent from the Parent/Guardian. If consent is not obtained, vaccines will not be administered.

Treatment of unaccompanied minor children will be at the discretion of the physician. Treatment may be refused based on the situation.

This form does not expire unless revoked in writing by the parent or guardian or when the patient turns 18.

____ ____________________

(Signature of Parent or Guardian) **(Date)**