Pediatrics of Steamboat Springs

940 Central Park Dr. Ste. 201 Steamboat Springs, Co 80487 Ph: 970-871-1900 Hayden Ph: 970-276-1900
Fx: 970-870-3138 WWW.PEDIATRICSOFSTEAMBOAT.COM
Ronald F. Famiglietti, M.D. Sheila M. Fountain, M.D. Dana M. Fitzgerald, M.D.
Patrick Grathwohl, M.D. Abigail Hoffner, RN NP-C

Consent to Treat Patient – Without Parent /Legal Guardian Present

Pediatrics of Steamboat Springs must receive permission from a child's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. If the party accompanying your child (baby-sitter, friend, relative, etc.) does not present this information, and we do not already have it on file, the clinic will attempt to contact you to request permission to treat your child.

NOTE:

- **A parent/legal guardian must attend a minor's first visit with Pediatrics of Steamboat Springs**
- **Minors may not receive immunizations without a parent or legal guardian present.**
- **In certain circumstances, in accordance with State and Federal laws, parent/guardian permission is not needed for adolescents being seen for such issues as STD testing, family planning, mental health, etc.**

This authorization is valid for:

☐ This visit only (date of appointment): _____ ☐ Until otherwise revoked

Section A (ONLY for child at least 16, but not 18 years old)

Authorization to treat your minor child in case you or your designated representative are unable to accompany your child to one of his/her visits: I, (print your name) _____ grant Pediatrics of Steamboat Springs permission to assess and treat the aforementioned minor without an adult present.

Section B (for child under 18 years old)

Delegation of authority for medical treatment of a minor child to the designated representative indicated below: I, (print your name) _____ grant Pediatrics of Steamboat Springs permission to assess and treat the aforementioned minor in the presence of any of the following **adults** (you may choose more than one), who is authorized to approve treatment:

Name: _____ Relation to minor _____
Name: _____ Relation to minor _____
Name: _____ Relation to minor _____

I agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

Patient's Name: _____ Patient's Date of Birth: _____

Authorized by: _____ Date: _____
Parent or Legal Guardian Signature

_____
Parent or Legal Guardian Printed Name