# Mia Bella Pediatrics

**26161 La Paz Road, Suite 115**
**Mission Viejo, CA 92691**

**CONSENT FOR TREATMENT OF MINOR**

I, _____________________________, legal guardian of ______________________________ give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child including, but not limited to, examination, injection, immunization and/or diagnostic procedures, including x-ray or laboratory analysis. I understand that only myself and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations) of my teen (16 years and older) without requiring the presence of an adult. However, if my teen needs immunizations and comes alone, a parent/guardian must be available by phone for verbal consent.

Name_____________________________

Phone (______) ________-____________

Relationship to Patient______________________

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment may be refused or delayed. I understand that in an emergency, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I have read all the information on this sheet and have provided the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify Mia Bella Pediatrics of any changes in the health status of my children or the above information.

**Whom may we contact in case of an emergency?**

Name_____________________________

Phone (______) ________-____________

Relationship to Patient______________________

**Completed by:**

Name_______________________________

Signature____________________________     Date______/_______/_________

Date as of 12/15/11