CARROLL CHILDREN'S CENTER

Michael J. Scobie, M.D. Peter K. Chung, M.D. Yasmeen Abernathy, M.D.
Cynthia Newton, PA-C Shannon Gibbons, PA-C Sarah Letos, PA-C
Wendy Gatto, CPNP

CONSENT FOR TREATMENT

I hereby authorize the care providers of Carroll Children's Center, and such assistants as may be designated, to perform usual sick and/or well care; including all necessary injections, tests, administration of treatment, screening, advice and follow-up care, for the welfare of:

______________________________ ______________________________
NAME OF PATIENT DOB NAME OF PATIENT DOB

______________________________ ______________________________
NAME OF PATIENT DOB NAME OF PATIENT DOB

______________________________ ______________________________
NAME OF PATIENT DOB NAME OF PATIENT DOB

My physician has offered to answer all inquiries concerning the proposed treatment/procedure. I understand that I am free to withhold or withdraw consent to the proposed treatment/procedure at any time. I hereby certify that I am eighteen years of age or older, or that I am the responsible legal guardian of the above-named patient.

_________________________ ____________________ ____________________
Signature of person giving consent Relationship to patient Date

COMPLETE ONLY IF APPLICABLE:

I hereby authorize the persons listed below to bring the above-named patient to this office for the care described above.

______________________________ ______________________________
Caretaker's name & relationship Caretaker's name & relationship

______________________________ ______________________________
Caretaker's name & relationship Caretaker's name & relationship

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Parent's/Guardian's Signature

For EMERGENCY in absence of parents, contact ______________________________

Relationship to patient _________________________ Phone # ____________________