Rocky Mountain Pediatric Surgery

Consent for Treatment without Parent/Guardian Present

Patient Name: _____ DOB: _____

Parent/Legal Guardian Name: _____ Phone: _____

I, _____, hereby voluntarily consent to the rendering of healthcare, including diagnostic testing, examination and/or medical treatment, by the physicians and other designated medical professionals of the Rocky Mountain Pediatric Surgery without me present.

I hereby give consent to the following individuals:

_____ and/or _____

to arrange for any medical care, and to make decisions in my place based on testing deemed necessary by the physician and medical team. This may include physical examination, lab work, medication injections/infusions, and/or any other treatment deemed necessary by my child's treating provider. I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

This consent is in effect for the following (please choose one)

☐ Date _____

☐ Date range from: _____ to: _____

☐ Until I revoke this document (Remainder of the current calendar year)

_____ _____

Parent / Legal Guardian Signature *Today's Date*