PERMISSION TO ACCOMPANY A MINOR

I, _____, give permission to _____
(Name of Parent/Guardian) (Name of adult to be accompanying child)
to accompany my child/children _____ and authorize treatment

for my child/children in accordance with the office policy of Pinecone Pediatrics. This includes bringing the child into the office of Pinecone Pediatrics and providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective from: _____ to _____.
(effective date) (end date)

Child's Health Information

Current prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Allergies, illnesses or other comments: _____
_____
_____

Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency?

Name_____ Phone: _____

Comments:_____
_____

Temporary Guardian Information

Name: _____ Phone: _____

Address: _____

Health Insurance Information ❒ No change since last visit *(skip to next section)*

Insurance Company:_____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

Parent or Legal Guardian's Signature: _____

Date:_____