



# Twelve Oaks Pediatrics

## Third Party Consent for Treatment and Examination

Patient Name(s): \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ DOB: \_\_\_\_\_

I, \_\_\_\_\_, the parent/guardian of  
the above named child(ren) give permission for:

\_\_\_\_\_ to seek medical care and treatment for him/her/them.

I can be reached by phone \_\_\_\_\_

I can be reached by email \_\_\_\_\_

I can be reached by fax \_\_\_\_\_

My signature below certifies my consent for examination and treatment of my child(ren). I understand that a parent/guardian **MUST** be present for well child visits and immunizations.

\_\_\_\_\_  
Signature of Parent and/or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

This consent is valid for one year from date of signature.