LITTLETON PEDIATRIC MEDICAL CENTER

CONSENT TO AND DIRECTION FOR TREATMENT OF MINOR

Patient Name:______________________________ **DOB** ______________________________

Authorization and Consent: I (We), being the parent(s) or guardian(s), entitled to the care, custody, and control of the above minor, do hereby authorize, request, and direct you to render such treatment to said minor, including without limitation diagnostic, medical, minor procedures, x-rays, and venipuncture.

Unaccompanied by Parent/Guardian: This consent to treatment is given in contemplation that the above minor may from time to time appear at Littleton Pediatric Medical Center for examination or treatment or both, unaccompanied by a custodial parent or guardian, because of my (our) absence or unavailability. I (We) hereby authorize, request and direct you to render treatment to said unaccompanied minor, including without limitation diagnostic, medical, minor surgical care, x-rays, venipuncture, and other care that requires a series of treatments to the extent I (we) have previously consented to the series of immunizations and/or treatments.

Parent/Guardian Participation: I (We) understand that at times the physicians, nurses, or administrators may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purposes of assisting in diagnosis or treatment. I (We) agree to cooperate by being present with said minor at all times possible or when requested.

Substitute Decision Maker: I (We) hereby grant authority to the following adult(s) to consent to care for my minor child should I not be available to provide consent at Littleton Pediatric Medical Center as allowed by Colorado Revised Statute (C.R.S.) 15-14-105, subject to the following limitations, unless prohibited by law:

Name:____________________________ Phone number: _________________

Relationship to Minor: _____________________ Street Address : _____________________________________

Name:____________________________ Phone number: _________________

Relationship to Minor: _____________________ Street Address : _____________________________________

__ All non-emergent, non-major care, including immunizations rendered at Littleton Pediatric Medical Center

__ Limited treatment, condition(s), procedure(s), and/or treatment as listed below:

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__ Please contact me (us) in the event a medical decision needs to be made for additional, unanticipated medical services beyond the reason for the patient's visit.

Expiration or Termination: All aspects of this consent will be in effect until specifically terminated or modified by written notice received by Littleton Pediatric Medical Center, or on the date the minor becomes an adult under state law.

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Signature of parent/guardian | Signature of parent/guardian

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Relationship to minor | relationship to minor

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Date | Date