Consent to Treat Minor

Names of Minor Children	Birth date

I/We, the biological parent(s) or legal guardian (s) of the above named children give permission for GWY to provide medical treatment as necessary for my child's health, including evaluations, perform diagnostic procedures and provide medical treatment as deemed necessary by the Provider.

We/I will be responsible to provide GWY with up to date pertinent history and conditon information prior to each appointment and to make arrangements to receive follow up instructions and treatment plans. If such efforts to communicate with me are unsuccessful, I authorize GWY to take approoriate action and give consent on my behalf as his/her judgement dictates.

AND, in addition I authorize the following adults and step-parents to make such medical treatment decisions as listed above, in my absence:

Name	Relationship	Phone Number

This authorization includes administering vaccinations and any other testing as deemed necessary by Provider. This authorization may be cancelled at any time, and shall remain active until such time it is cancelled in writing, or a new updated authorization is received. I/We understand that we are responsible for all reasonable charges in connection with the care and treatment of my children listed above.

Parent/Legal Guardian________________________________ Date______________________

Printed Name ________________________________ DOB______________________

Growing With You Pediatrics
1075 Golden Valley Drive Bettendorf, IA 52722 Phone:563-900-5996 Fax 563-900-5997