**Center for Pediatric Adolescent Gynecology**

Lawrence Amesse, MD, PA

Consent by Parent or Legal Guardian for Minor Patient

(Younger than 18 yrs of age)

Name of Minor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My signature below acknowledges that:

1. I am the ☐ parent ☐ legal guardian of :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Minor

1. I have legal authority to consent for the medical evaluation and the treatment of the above minor.
2. I authorize all diagnositic, medical treatments and/or surgical procedures for the above named minor by the physician at the Center for Pediatric Adolescent Gynecology as determined appropriate for the management of any medical condition.
3. I give permission that treatment may be provided in my absence.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name of Parent or Legal Guardian (please print) Relationship to Minor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of the Parent or Legal Guardian Date Signed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Witness Date Signed