**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

2. I have legal authority to consent for the medical evaluation and the treatment of the above minor.

3. 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.

4. 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