Westchester Park Pediatrics
Affiliated with Boston Children's Health Physicians

MINOR CONSENT

For Children Under Age 18

I authorize my child ________________________________ , Date of Birth _______________

to be seen on _________________________ (date) by Boston Children's Health Physicians, LLP.

1. **Alone or Accompanied to Appointment:**

___ My child may be seen without being accompanied by anyone.

___ My child may be seen only accompanied by _____________________ and CWPW personnel.

2. **Alone or Accompanied in Examination Room:**

___ My child may be seen and treated in the examination room without being accompanied by anyone.

___ My child may be seen and treated in the examination room only accompanied by _____________________ and CWPW personnel.

___ I authorize any test, procedure, and/or vaccination to be done on my child in the course of treatment.

3. **This authorization is valid for the following date or period of time** ______________.

Parent/Guardian Signature ______________________________________

Print Name ____

Date ____

FOR VERBAL CONSENT OBTAIN ANSWERS TO #1, 2 AND 3 ABOVE

Date _________________________________

Verbal consent obtained by phone call at: ____
Phone number received from or called and time of call

____
Name of person giving verbal consent and relationship to patient

Witnessed by: ____

____

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