Drs. Black & Benton Pediatrics, PSC

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Consent to Routine Medical Care/Treatment for Minors

Parent/Guardian Consent:

I, ____give permission for my minor child/children:
(parent/guardian name)

____
(list all children here)

to receive routine medical treatment at Drs. Black & Benton Pediatrics P.S.C. under the supervision of any and all of the following named adults in my absence. I understand that a government issued picture identification will be required of the adult supervising the child at the time of the service.

Last Name	First Name	Relationship to Child
(List all adults you give permission to bring your children to our office; legal parents/guardians do not need to be listed.)		
_____________________	______________________	_________________________
_____________________	______________________	_________________________
_____________________	______________________	_________________________
_____________________	______________________	_________________________
_____________________	______________________	_________________________
_____________________	______________________	_________________________
_____________________	______________________	_________________________

_______________________________________ _______________________
Signature of Parent/Guardian *Date*

_______________________________________ _______________________
Witness Signature *Date*