

# Children's & Women's Physicians of Westchester, LLP

## Herbert Kania Pediatric Group

### MINOR CONSENT

#### For Children Under Age 18

I authorize my child \_\_\_\_\_, Date of Birth \_\_\_\_\_

to be seen on \_\_\_\_\_ (date) by Children's & Women's Physicians of Westchester, 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 \_\_\_\_\_

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#### 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: \_\_\_\_\_

\_\_\_\_\_