Caregiver Consent

COTTONWOOD PEDIATRICS | 700 MEDICAL CENTER DR, STE 150 | NEWTON, KS 67114 | P: 316-283-7100 | F: 316-283-7118

Cottonwood Pediatrics

CHILD 1: FULL NAME _____ DOB _____

CHILD 2: FULL NAME _____ DOB _____

CHILD 3: FULL NAME _____ DOB _____

CHILD 4: FULL NAME _____ DOB _____

When I/we, the undersigned parent(s) or legal guardian(s) of the child/children listed above, are not present, I/we authorize

NAME OF NON-PARENT BRINGING TO APPT	PHONE NUMBER	RELATIONSHIP TO CHILD/CHILDREN

to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, immunizations, injections or treatment and/or hospital care to be provided to said child/children when such services are recommended and supervised by Cottonwood Pediatrics. I/We authorized Cottonwood Pediatrics to call in, at their discretion, any necessary consultants.

I understand that, despite this consent, Cottonwood Pediatrics, in its sole discretion, **may decide not to act on this consent** and instead require my presence during my child/children's treatment or care.

I also understand that **I am financially responsible for any co-pays and charges not covered by my insurance which are incurred as a result** of this consent for treatment and care.

Unless it is revoked sooner in writing, this consent remains in effect until:

☐ my child/children is/are 18 years old **OR** ☐ date (MM/DD/YYYY) _____/_____/_____ .

COPY OF INSURANCE CARD(S) AND COPAY(S) ARE ALWAYS DUE AT CHECK-IN.

TODAY'S DATE	PARENT/GUARDIAN'S SIGNATURE	RELATIONSHIP TO CHILD

Please fill out form BEFORE your child/children's appointment to avoid delays in treatment. Sign it and mail, fax or upload on our website cottonwoodpeds.com/upload.