Check pediatric office location where you are being evaluated: _____

I give consent for _____ to receive routine medical care, including health
(Child's Name)

supervision visits, immunizations, and treatment of ordinary illness in my absence.

Please select either A or B:

☐ A. My child will be accompanied to his/her visit(s) by:

Name of Chaperone:	Name of Chaperone:	Name of Chaperone:
Name of Chaperone:	**Name of Chaperone:**	**Name of Chaperone:**

The chaperones above have my permission to sign the consent for any required immunizations and/or to accept medical advice, medicines, and other information on my behalf.

☐ B. My child is 16 years of age or older and will be coming to his/her visits without a chaperone. My child has my permission to sign the consent for any required immunization and/or accept medical advice, medicines, and other information on my behalf.

Person Completing Form

_____ _____ _____ _____
(Signature) *(Printed Name)* *(Date)* *(Time)*

_____
(Relationship to Patient)

Office Coordinator_____ _____ _____ _____
(Signature) *(Printed Name)* *(Date)* *(Time)*

UPMC LIFE CHANGING MEDICINE

UPMC PEDIATRICS
MINOR CONSENT

PATIENT IDENTIFICATION

Form 39346-05 (01/22) MR (InD)
Aztec Barcode 2000