

**Consent to Treatment of a Minor by Memphis Pediatrics, PLLC When  
Parent/Guardian Are Temporarily Unavailable**

The undersigned parent or legal guardian of \_\_\_\_\_ authorizes the person(s) below  
(Child's Name)  
to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic,  
or surgical services when I am not available in person, or by a telephone call to \_\_\_\_\_.  
(Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and  
allows the physician to diagnose and treat the child even when the parent or guardian is not  
present.

1. Person(s) who may consent to treatment (please print):

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Phone: \_\_\_\_\_

2. Medical Concerns: \_\_\_\_\_

3. Known allergies: \_\_\_\_\_

Name of Parent of Legal Guardian: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
(Print Name)

Contact Number(s): \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This consent is effective with Memphis Pediatrics, PLLC until withdrawn in writing by the child's  
parent or guardian.