

Princeton Nassau Pediatrics Parental Consent Form

I, _____ (Name of Guardian/Relationship to patient/DOB), give permission for _____ (patient's name/DOB) to be examined and treated at Princeton Nassau Pediatrics for the following time period

_____.

I authorize: _____ (Name/Relationship/DOB)
_____ (Name/Relationship/DOB)
_____ (Name/Relationship/DOB)

To make medical decisions, consent for diagnostic testing (lab work and ordering of radiology studies), immunizations, minor laceration repairs/incision and drainage of abscesses, medication administration, and other medical care that the medical professionals at Princeton Nassau Pediatrics deem necessary for treatment. I authorize the listed LARs to sign registration forms at the time of medical visits.

_____ (Legal Guardian Signature and Date)

_____ (Phone Number of Legal Guardian)

_____ (Allergies of Minor)