Pediatric Surgical Associates, Ltd.

Temporary Consent to Accompany a Minor

I verify that a legal parent/guardian has given authorization to (**Name of accompanying adult**):

_____ to accompany:

(**Child's Name & DOB**): _____ _____ to his or her medical appointment on

(**Date**): _____.

I understand that as a non-custodial adult, this form does not give me authorization to consent to any medical or surgical diagnosis or treatment, x-ray examination and/or medical care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act at Pediatric Surgical Associates, Ltd.

Full Name, Phone Number and Relationship of Child's Legal Parent/Guardian(s):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Signature **Relationship to Child** **Date**