

**Consent for Treatment by an Adult**  
**Other Than Parent or Legal Guardian**

South East Bay Pediatric Medical Group  
2191 Mowry Ave., Ste. 600C, Fremont CA 94538  
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This form allows parent(s) or legal guardians to designate another adult (for example, a grandparent or other relative or adult 18 years or older) into whose care the minor patient has been temporarily entrusted in order to bring their child in if parent(s) or legal guardian(s) are unable to be present at the appointment.

Child's Name: \_\_\_\_\_  
Child's Date of Birth: \_\_\_\_\_  
Name of Adult Designee: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

The above named person has my permission to bring my son or daughter to his/her scheduled appointment(s). I authorize the physicians of South East Bay Pediatric Medical Group, Inc. to perform on my child any necessary or routine medical or surgical treatments, including examination, injections, immunizations, and/or diagnostic procedures, including radiologic studies and/or laboratory analysis. I understand that in unusual circumstances efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain in effect unless so designated in writing that such consent for treatment of a minor is rescinded.

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

Name: \_\_\_\_\_

mother       father       legal guardian

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

Name: \_\_\_\_\_

mother       father       legal guardian