Consent for Medical Decision Making

Relative accompanying patient:

I, _____, parent/legal guardian of _____

DOB _____ authorize _____ to make medical decisions and consent to routine medical care, including point of care testing and vaccination, as recommended by the provider at Thrive Pediatrics PLLC.

_____ _____

Signature Date

Unaccompanied teenage minor:

I, _____, parent/legal guardian of _____

DOB _____ authorize Thrive Pediatrics to provide routine medical care to my child, including point of care testing and vaccinations.

_____ _____

Signature Date