Cottonwood Pediatrics
700 Medical Center Dr, Ste 150
Newton KS 67114
316-283-7100

www.cottonwoodpeds.com

Consent to Treat

(For stepparents of minor children)

TO AVOID DELAYS IN TREATMENT
Please return this completed form by mail to the address above,
or by fax to 316-283-7118,
BEFORE the child's appointment

I/We the undersigned parent(s) of the child listed below:

_____ _____
Child's name Date of Birth

authorize: _____, the stepparent of this child by marriage to ☐ father ☐ mother
Name of stepparent of this child

to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, immunizations, injections or treatment; and/or hospital care to be provided to said child, when such services are recommended and supervised by Cottonwood Pediatrics. I/We authorize Cottonwood Pediatrics to call in, at their discretion, any necessary consultants.

All of the undersigned understand they **may be held financially responsible**, and while one parent may have signed this consent, **it was a joint parental decision**, and it is in the best interests of the child to have the above treatments and care consented to by the stepparent.

Despite this consent, Cottonwood Pediatrics, in its sole discretion **may decide not to act on this consent**, and instead require the presence of a parent during my child's treatment or care.

Unless it is revoked sooner in writing, this consent remains in effect until my child is
☐ 18 years old ☐ until the _____ of _____, 20 ___.

_____ _____ _____
Father's signature OR Mother's signature Date

Parent's address: _____ Phone: _____

Parent's employment: _____ Phone: _____

Other phone number(s) at which parent can be reached: _____

Child's known allergies: _____

Other significant health problems: _____

Date of child's most recent tetanus shot: _____

Medications currently being given to child: _____

I agree to see to, and may consent to, the above-named child's medical care, as provided on this form.

_____ _____ _____
Stepparent signature Date Address and phone