



www.cottonwoodpeds.com

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

Temporary Consent to Treat
(For caregivers 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) or legal guardian of the child listed below:

Child's name Date of Birth

authorize: Name of adult who is the temporary caregiver of this child

the temporary caregiver of this child, to consent to any X-ray examination, anesthetic, medical or
surgical diagnosis, 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.

This consent shall remain in effect until midnight on the \_\_\_ day of \_\_\_,
20\_\_\_, unless it is revoked sooner in writing (may be no more than one year in advance).

Father's signature AND/OR Mother's signature

Date OR Legal Guardian's signature

Parent / guardian's home address: Phone:

Parent / guardian's place of employment: Phone:

Other phone number(s) at which parent or guardian 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.

Custodian's signature Date

Custodian's address Phone: