Boston Children's Health Physicians
Until every child is well℠
formerly CWPW

MINOR CONSENT

For Children Under Age 18

I authorize my child _____, Date of Birth _____

to be seen on _____ (date) by Boston Children's Health Physicians, LLP.

1. **Accompanied to Appointment:**

___ My child may be seen only accompanied by _____ and BCHP personnel.

2. **Accompanied in Examination Room:**

___ My child may be seen and treated in the examination room only accompanied by _____ and BCHP personnel.

3. **This authorization is valid for the following date or period of time** _____.

Parent/Guardian Signature _____

Print Name _____

Date _____