



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. Alone or Accompanied to Appointment:

___ My child may be seen without being accompanied by anyone.

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

2. Alone or Accompanied in Examination Room:

___ My child may be seen and treated in the examination room without being accompanied by anyone.

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

___ I authorize any test, procedure, and/or vaccination to be done on my child in the course of treatment.

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

_____.

Parent/Guardian Signature _____

Print Name _____

Date _____

FOR VERBAL CONSENT OBTAIN ANSWERS TO #1, 2 AND 3 ABOVE

Date _____

Verbal consent obtained by phone call at: _____
Phone number received from or called and time
of call

Name of person giving verbal consent and relationship to patient

Witnessed by: _____

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