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: _____

_____