



CONSENT FOR MEDICAL SERVICES

I have been informed of the types of services I will receive and I voluntarily consent for my child _____ to be examined and evaluated by Delta Pediatrics. I also agree to any routine test to be administered as deemed necessary. Included in this agreement is permission for treatment as indicated and referral to other appropriate health facilities when necessary.

Signature of Parent/Legal Guardian

Date

*** IF PATIENT IS UNDER 18 YEARS OF AGE, A PARENT OR LEGAL GUARDIAN MUST SIGN***