



glenbrookpediatrics

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Parental Consent for Treatment of an Unaccompanied Minor Child

I, the undersigned parent or legal guardian of (Child's Name) _____,
a minor child whose date of birth is _____, by this written
authorization do hereby authorize and indicate my consent and delegation of my authority
for the medical evaluation, diagnosis and treatment of my child listed above to the
physicians of Glenbrook Pediatrics, S.C. in the event I am unable to accompany my child to
the physician's office.

I agree to and hereby grant Glenbrook Pediatrics, S.C. authorization to provide any
treatment deemed appropriate in the physician's professional judgment including the
administration of immunizations and/or any diagnostic or laboratory testing to my child
_____ in my absence.
(Child's Name)

Nothing herein shall be deemed as my request, direction, authorization or consent for any
examination, testing, treatment or other medical service for which the physician, in his or
her professional judgment, deems inappropriate or not medically necessary.

I understand that this consent is valid until it is revoked by me or revoked by the
physician and that I may revoke this consent at any time by giving written notice of my
desire to do so to the physician.

Signature: _____ Date: _____

Relationship to Patient: _____