Wildflower Pediatrics, PA
11609 Anderson Mill Road
Austin, Texas 78750

PEDIATRIC PERMISSION TO TREAT 16 YEAR OLD AND 17 YEAR OLD ADOLESCENTS

Sometimes your 16 or 17 year old adolescent may come to the office alone. If your child may do so, please indicate below.

I, ______________________________________ do hereby grant permission to the providers at Wildflower Pediatrics, to treat my child ________________________ (Date of Birth: ___/___/___), in the event of an emergency or anytime he/she presents to the office requesting medical care when not accompanied by an adult.

Vaccines cannot be administered at any visit without a parent or legal guardian present.

Other people who have permission to bring my child for medical care:
(Must be 18 years or older)

Name & Date of Birth	Relationship
______________________________________	__________________________
______________________________________	__________________________
______________________________________	__________________________

____ _____________
Parent/Legal Guardian Signature Date