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CONSENT FOR NONURGENT MEDICAL PEDIATRIC CARE

In my absence I, (print) _____, who has the legal custody of my child,
(Parent/Legal Guardian)

(print) _____ and whose birth date is __/__/____,
(Child's name) mm/dd/yyyy

Authorize(print) _____ to provide consent to Holyoke Pediatric Associates to render
(Consenting adult)

care under the supervision and advice of a Pediatrician or other medical care professional.

Please initial below the items you wish to allow the above individual to consent:

- (initials) _____ Scheduling appointments
- (initials) _____ Medical exams and treatments
- (initials) _____ Surgical exam and treatments
- (initials) _____ Diagnostic imaging procedures
- (initials) _____ Laboratory tests
- (initials) _____ Immunizations
- (initials) _____ Triage advice by telephone

By signing this form, I am agreeing for the above individual to consent for my child from

__/__/____ to __/__/____. This consent may be removed at any time by the parent/legal guardian,
mm/dd/yyyy mm/dd/yyyy

if requested in writing.

Sign: _____ Date _____
(Parent/Legal Guardian Signature)