



Manchester Pediatric Associates LLC
2701 Tamarack Ave
South Windsor, CT 06074
Tel: 860-647-8282 Fax: 860-647-8399

Consent Form for Child's Medical Appointment

Child's Full Name: _____

Date of Birth: _____

I, the undersigned parent, or legal guardian of the above-named child, hereby grant permission to _____ to accompany and represent me at my child's medical appointment on _____ for the purpose of receiving medical care and services.

Family Member's Full Name

Appointment Date

I understand and agree to the following:

1. MPA is authorized to provide necessary medical care, examinations, and treatments to my child during this appointment.
2. I understand that my family member, _____, is acting as my authorized representative during the appointment and is authorized to provide consent for medical procedures as deemed necessary by the healthcare provider.
Family Member's Full Name
3. I release and hold harmless MPA and their staff from any liability for any medical treatments or services provided to my child during the appointment.
4. I grant permission for MPA to share any medical information related to this appointment with the _____ accompanying the child.
Family Member's Full Name
5. I hereby give my informed consent for my child to receive any recommended vaccines during the appointment. I understand that vaccines are an important part of preventive healthcare and will follow the healthcare provider's recommendations regarding vaccinations.
6. I understand that this consent form is valid only for the specified appointment on _____ and does not grant ongoing or general consent for medical care in the future.
Appointment Date
7. I certify that the information provided on this form is accurate and complete to the best of my knowledge.
8. I acknowledge that I have read and understood the information on this form and agree to all of its terms.

Parent/Legal Guardian's Full Name: _____

Parent/Legal Guardian's Signature: _____

Date: _____