Patient Name: ___________________________ DOB: ____________

## **Consent for Treatment**

I hereby voluntarily consent to care for my child encompassing diagnostic procedures and medical treatment by my physician, her assistants or her designees as may be necessary in her judgment.

Initials: ____

I agree for my child to have HIV and other communicable disease testing in the event of a healthcare worker being exposed to my child's bodily fluids.

Initials: ____

I agree for my child to have photographs take of appropriate parts of my child body in order to provide supporting of my child's medical conditions. I understand that any photographs taken will be placed in and remain part of my child's medical record.

Initials: ____

**This form has been explained to me and I certify that I understand its contents.**

____________________________________ ___________________________

Parent or Legal Representative Date

____________________________________

Relationship to Patient: