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## Livermore Pleasanton San Ramon Pediatrics Group

Infants • Children • Adolescents

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### Consent to Treat

I the undersigned parent(s) / guardian of \_\_\_\_\_, *(child's full name)*                      *(date of birth)*  
\_\_\_\_\_, *(child's full name)*                      *(date of birth)*  
\_\_\_\_\_, *(child's full name)*                      *(date of birth)*  
\_\_\_\_\_, *(child's full name)*                      *(date of birth)*  
\_\_\_\_\_, *(child's full name)*                      *(date of birth)*

a minor child, do hereby consent to any examinations, laboratory tests and x-rays as necessary; repair of lacerations; referral to an urgent care or emergency room when medically indicated for diagnosis and/or treatment that may be rendered to said minor. It is understood that this consent is given in advance of any specific diagnosis or treatment.

This consent shall remain effective until revoked in writing and received by Livermore/Pleasanton Pediatrics.

Mother: \_\_\_\_\_  
*(print name)* *(signature)* *(date)*

Father: \_\_\_\_\_  
*(print name)* *(signature)* *(date)*

Legal Guardian: \_\_\_\_\_  
*(print name)* *(signature)* *(date)*