**Child's Information:**

1. **Child's Full Name:** [Child's Full Name]
2. **Date of Birth:** [Child's Date of Birth]
3. **Gender:** [Male/Female/Other]
4. **Address:** [Child's Address]
5. **Parent/Guardian Name(s):**
   * [List the names of the parent(s) or legal guardian(s)]

**Healthcare Provider Information:**

1. **Healthcare Provider Name:** [Provider's Full Name]
2. **Clinic/Hospital Name:** [Name of Clinic or Hospital]
3. **Contact Information:** [Provider's Phone Number and Email Address]

**Description of Medical Procedure/Treatment:**

1. **Name of Procedure/Treatment:**
   * [Specify the name of the medical procedure or treatment]
2. **Purpose of Procedure/Treatment:**
   * [Explain the purpose and significance of the medical procedure or treatment]

**Explanation of Procedure:**

1. **Description of Procedure:**
   * [Provide a detailed description of the procedure, including potential risks and benefits]
2. **Alternative Options:**
   * [Explain any alternative options available, if applicable]

**Consent and Authorization:**

1. **Consent for Procedure/Treatment:**

* I, as the parent or legal guardian, voluntarily consent to the specified medical procedure or treatment for my child.
* I decline to consent to the specified medical procedure or treatment for my child.

1. **Authorization for Emergency Treatment:**

* I authorize emergency medical treatment for my child if necessary during the procedure or treatment.

1. **Authorization for Release of Information:**

* I authorize the release of medical information to relevant healthcare providers for the purpose of my child's care.

**Parent/Guardian Acknowledgment:**

1. **Understanding:**
   * I have had the opportunity to ask questions and have received satisfactory answers.
2. **Risk and Benefits:**
   * I have been informed about the potential risks and benefits associated with the procedure or treatment.

**Declaration and Signature:**

I, the undersigned parent or legal guardian, acknowledge that I have read and understood the information provided in this Pediatric Consent Form. I voluntarily consent to the specified medical procedure or treatment for my child.

**Parent/Guardian's Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** [Date]

**Witness (if applicable):**

I, the undersigned witness, confirm that I have witnessed the parent or legal guardian's signature on this Pediatric Consent Form.

**Witness Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date:** [Date]