PEDIATRIC CONSENT FOR TREATMENT FORM

I, (Guardian name)_____, of sound mind hereby consent and grant permission to the physician, Tuan M Vo DO and other staff at Sunrise Family Medicine PLLC to participate and treat my child/the minor in my care:

(Name of Child) _____

The physician may review any medical condition and address any medical concerns within the standard of care of Osteopathic Family Medicine, associated complimentary and integrative medicine practices that may include but are not limited to the assessment of their medical history, clinical exam, laboratory testing, imaging, as well as Osteopathic Manual Therapy, Medical Acupuncture and other approved therapies that fall within the practice of the treating physician. I further understand and accept the risks and benefits of such treatment for the child's medical care. I understand and accept these risks and release Dr. Tuan M Vo DO and all his staff at Sunrise Family Medicine PLLC from all liability should any unanticipated adverse events occur during my child's treatment with the expectation that treatment will proceed in good faith and professional manner to the highest standard of care.

I understand that Dr. Tuan M Vo DO and his staff, will do their best to maintain to the best of their ability the safety and integrity of my child, and do what is in my child's best interest to better their health and help care for their mind and body.

Patient Name/Age: _____

Guardian Name:_____

Date: _____

Acknowledged by Sunrise Family Medicine PLLC Staff:

Dr. Tuan Minh Vo Do

Date: _____