JELLYBEAN PEDIATRICS, LLC

Parent Authorization & Permission to Treat Form

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Reference Copy

This document is provided so families can review the forms used by Jellybean Pediatrics before enrollment. Official enrollment paperwork will be completed electronically after joining the practice.

Patient Information

Patient Name: _____

Date of Birth: _____

Parent/Guardian Information

Parent/Guardian #1: _____

Relationship to Patient: _____

Phone Number: _____

Email Address: _____

Parent/Guardian #2 (optional): _____

Relationship to Patient: _____

Phone Number: _____

Email Address: _____

Emergency Contact

This individual may be contacted if a parent or legal guardian cannot be reached.

Name: _____

Relationship to Patient: _____

Phone Number: _____

Authorized Caregivers

The following individuals are authorized to bring my child to appointments, participate in discussions regarding my child's care, and consent to non-emergency medical evaluation and treatment when I am unavailable:

1. _____

Relationship: _____
Phone: _____

2. _____

Relationship: _____
Phone: _____

3. _____

Relationship: _____
Phone: _____

Communication Authorization

I authorize Jellybean Pediatrics to discuss my child's medical care with the following individuals:

☐ Mother

☐ Father

☐ Legal Guardian

☐ Authorized Caregivers listed above

☐ Other: _____

☐ I authorize Jellybean Pediatrics to leave voicemail messages regarding my child's care.

☐ I authorize Jellybean Pediatrics to communicate with me regarding my child's care by phone, secure messaging, text message, and email.

Permission to Treat

I authorize Dr. Lauren Beene and Jellybean Pediatrics to provide medical evaluation and treatment for my child.

I understand that treatment recommendations will be based on professional medical judgment and may include referral to outside services, urgent care, emergency care, specialty care, laboratory testing, imaging, or other services when clinically appropriate.

Emergency Authorization

In the event that I cannot be reached in a timely manner, I authorize Jellybean Pediatrics to provide medically necessary evaluation and treatment and to arrange emergency medical services when clinically indicated.

I understand that emergency medical care may require referral to an Emergency Department or activation of emergency medical services (911).

House Call Acknowledgment

I understand that:

• A responsible adult age 18 years or older must be present for all house call visits.

• House calls may be rescheduled, modified, or canceled due to safety concerns, weather, travel conditions, or clinical considerations.

• Jellybean Pediatrics may determine that an in-person house call is not appropriate and may recommend telemedicine, urgent care, emergency care, or another level of care.

Acknowledgment

By signing below, I certify that I am the parent or legal guardian of the patient listed above and have authority to make medical decisions on the patient's behalf.

Parent / Guardian

Printed Name: _____

Relationship: _____

Signature: _____

Date: _____