Guardian Consent for Pediatric Intravenous (IV) Therapy

Patient Information:

Child's Full Name: _____
Date of Birth: _____
Medical Record Number (if known): _____

Guardian Information:

Parent/Legal Guardian Name: _____
Relationship to Child: _____
Contact Phone Number: _____

Clinic and Procedure Details:

Clinic Name: _____
Prescribing Physician: _____
Type of IV Therapy/Medication: _____

Authorization and Consent:

I, the undersigned, am the parent or legal guardian of the child named above. I hereby authorize the medical staff at the clinic listed above to perform intravenous (IV) therapy as prescribed by my child's physician.

I understand that this procedure involves the insertion of a needle into a vein to administer fluids, medications, or nutrients. I acknowledge that I have been informed of the benefits and potential risks associated with IV therapy, including but not limited to: bruising, swelling, infection at the site, or allergic reactions.

I confirm that I have had the opportunity to ask questions and that all my questions have been answered to my satisfaction. I understand that I may withdraw this consent at any time prior to the commencement of the procedure.

Emergency Contact (if different from guardian):

Name: _____
Phone: _____

Signatures:

_____

Signature of Parent/Legal Guardian

_____

Date Signed

_____

Witness Signature (Clinic Staff)