Minor Child Consent to Treat

In Absence of a Parent or Guardian

Family Health Center

Patient Name :	Date of Birth :

I, _____(Parent/Guardian Printed Name), give my permission for my child to be evaluated and treated at the Family Health Center and/or their school in my absence. In addition, I give permission for the provider to share any relevant health information with the person accompanying my child. My child will be accompanied by:

☐ Him/Herself

☐ Relative/Other

Name :	Date of Birth :
Phone Number :	Relationship:

Name :	Date of Birth :
Phone Number :	Relationship:

Name :	Date of Birth :
Phone Number :	Relationship:

If I am unable to bring my child for treatment at the Family Health Center, the individuals listed above may bring in my child for treatment which may include:

- ✓ Physical Exam and/or Screen (such as vision and blood pressure)
- ✓ Immunizations
- ✓ Blood and/or Urine Tests
- ✓ First Aid and Emergency Care
- ✓ Prescription and Treatment for Illness
- ✓ Psychotherapy
- ✓ Referrals to an Outside Facility or Service (such as Radiology or Specialist)
- ✓ Substance Use Treatment
- ✓

I understand that this consent is only available for one year from the date of signature. If changes need to be made to this list at any time during the year, it will be necessary to complete a new form.

x

_____ _____

Signature of Authorized Representative Date