Consent for Treatment of a Minor

(For use when parent is designating a representative)

Family Health Network must receive permission from a child's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. If the designated representative accompanying your child (baby-sitter, friend, relative, etc.) does not present this information the clinic will attempt to contact you to request permission to treat your child.

NOTE:

- Child must be an established patient (a patient known to the practice and seen within the past 12 months).
- A new "Consent for Treatment of a Minor" form is required for each visit that a minor will be seen without his/her parent/legal guardian.
- In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of "heightened sensitivity" such as STD testing, family planning, mental health, etc as noted in Policy and Procedure "Treatment of a Minor"

I, _____, parent/legal guardian of_____
(Parent/ Legal Guardian Name) (Minor's Name)

grant permission to _____, to accompany my son / daughter as
(Designated representative)

named above to his / her medical / dental visit on _____ at _____
(Date of appt.) (Name of Facility)

I understand that if the provider seeing my child deems it necessary that a medical care decision needs to be made or a non-routine procedure performed on my son / daughter, I will be contacted for permission to any action being taken at _____.
(Phone number)

I consent that the person named above has the authority to agree to any non-invasive testing or routine procedures including, but not limited to, in-office testing, physical examinations, and immunizations. I also understand that the above named representative will be asked to provide proof of who he/she is. I acknowledge that we are responsible for all charges in connection with the care and treatment rendered.

_____	_____	_____
Date	Parent/ Legal Guardian Signature	Witness(es)

Verification of Signature _____
(Staff signature)

Document used for verification_____