unitedregional

Consent for Treatment of a Minor without Parent Present

I give permission for my child to be medically evaluated and treated in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation. I accept responsibility for physician charges, laboratory and radiology fees for service.

This consent applies to:

- Complete physician check-up including any point of care testing
- Immunizations
- First aid or emergency care
- Prescription and treatment for illness
- Referral and treatment to outside facilities for services not provided in this office.

If there are any services that you do not consent to in your absence please list:

_____

_____

_____

My child may be accompanied by:

□ Himself/herself

□ Caregiver (name) _____

□ Other (name/relationship) _____

I give permission for the physician to share any relevant health information with the person/persons accompanying my child at their visits.

_____ _____

Child's Name Date

_____ _____

Parent/Guardian Signature Parent/Guardian Name

_____

Contact telephone number where Parent/Guardian can be reached