Consent to Treat Minor Patient-Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, or arrives unaccompanied, we must have written permission from the parent or legal guardian that the person accompanying the minor has been appointed by you to act on your behalf, or that the minor can act on their own behalf.

Minor's Name: _____ Date of Birth: _____

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

Name: _____ Phone: _____ Relation to Patient: _____

Name: _____ Phone: _____ Relation to Patient: _____

Name: _____ Phone: _____ Relation to Patient: _____

Name: _____ Phone: _____ Relation to Patient: _____

Name: _____ Phone: _____ Relation to Patient: _____

Name: _____ Phone: _____ Relation to Patient: _____

LIMITATIONS: Identify any specific limitations on the kinds of services for which this authorization is given. (If none, state "none").

_____

AUTHORIZATION: I (parent/legal guardian name) _____ request and authorize Family Health Services of Darke County, Inc. and its personnel to deliver routine medical care to the minor person listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor person. I am also aware that the adult presenting the minor, or the minor is responsible for payment of the patient portion at the time of service. I have the legal right to preauthorize Family Health Services of Darke County, Inc. and its personnel to deliver routine medical treatment and services to the minor. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam, immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations). I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

This consent shall be in effect for ☐ Date: _____ (Only) ☐ Indefinitely, until revoked by written notice.

_____

Parent or Legal Guardian (please print) Phone Number Relationship

_____

Parent/Guardian Signature Date

Return to Family Health in-person or send to:
Fax: 937.548.2087
Email: medicalrecords@familyhealthservices.org