

**CONSENT FOR TREATMENT OF MINOR**

I, \_\_\_\_\_, legal guardian of \_\_\_\_\_ give the following adult permission to make decisions regarding the necessary and/or routine treatment of my child including, but not limited to, examination, injection, immunization, and/or diagnostic procedures, including x-rays or laboratory analysis. I understand that only myself and those listed below will have the authority to authorize treatment. I also authorize treatment (except for immunizations) of my teen (16 years or older) without requiring the presence of an adult. However, if my teen needs immunizations and comes alone, a parent/guardian must be available by phone for verbal consent.

Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

I understand that any person bringing the patient in for treatment not listed above must have a letter of consent from me or treatment may be refused or delayed. I understand that in an emergency, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated in writing that such consent for treatment of minor is cancelled. I have read all the information on this sheet and have provided the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify SCIP of any changes in the health status of my children or the above information.

**Whom may we contact in case of an emergency?**

Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**Completed by:**

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_