



Arbor Family Medicine



CONSENT TO TREAT A MINOR

Caregiver other than Parent/Guardian

PATIENT NAME

DATE OF BIRTH

LAST	FIRST	MONTH	DAY	YEAR
	SIBLING	MONTH	DAY	YEAR
	SIBLING	MONTH	DAY	YEAR
	SIBLING	MONTH	DAY	YEAR

I,

FULL NAME OF PARENT OR GUARDIAN

above guardian of the above name child(ren) give the following adults permission to make decisions regarding the necessary and/or routine treatment of my child(ren) including but not limited to, examinations, injection, immunization and/or diagnostic procedures including X-ray 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 immunization) of my teen child (16 years and 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 (AUTHORIZED CAREGIVER(S))	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 could be refused or delayed. I understand that in an emergency, efforts will be made to contact 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 will notify Arbor Family Medicine, PC of any changes in the above information.

I have read all the information on this sheet and certify that the information I have provided here is true and correct to the best of my knowledge.

SIGNATURE	RELATIONSHIP TO MINOR	DATE