Medical Treatment of a Minor: Patient Information and Consent

Today's Date:__________Patient Name:____Date of Birth:__________

Last First Middle or Maiden

Parent or Custodian Information

Patient or Custodian Name: ____

Address:______________________________ City:____________________ State:______ Zip: __________

Authorization

This authorization applies to the following children: ____

____

I have the authority to consent to medical treatment of the foregoing child(ren) in that I am a: (Check one)

☐Parent (other than possessory conservator)
☐Guardian of the person
☐Managing conservator of the child(ren)

By my signature hereto, I hereby give authority to ____
to consent to medical treatment for the foregoing child(ren) in the event that I cannot be contacted. The foregoing person to whom I give such authority is related to the child(ren) as follows:

☐An educational institution in which the child(ren) is/are enrolled
☐An adult who has care and control of the child(ren)

Specific Information

Name of Procedure: ____

Additional risks: (To be completed by provider) ____

Parent or Custodian Consent

I have read or had read to me the contents of this form, reviewed and understand this list, understand the risks and alternatives of this procedure, and have been given an opportunity to ask any questions I have about this treatment with the provider.

Parent or Custodian Signature: ____ Date:__________

If someone other than the parent or custodian completed this form, please give name & relationship:

____ ______________________________
Name Relationship

Witness Signature: ____ Date:__________

Address:______________________________ City:____________________ State:______ Zip: __________

Provider Signature:____ Date Reviewed:______________

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Please return completed form to the appropriate physician's office.

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