Marcella Bonnici, MD
Consent for Treatment for a Minor

Patient Name: _____ D.O.B: _____ Today's Date: _____

1) I, the undersigned parent/guardian of _____, a minor, do hereby authorize and direct Marcella Bonnici, MD and the staff at Dr. Bonnici's to provide ongoing routine and emergency health care. This consent shall remain in effect until _____ or until revoked in writing.
Parent's/Guardian's Name_____ Signature _____Date _____
Witness' Name: _____ Signature: _____ Date: _____

2) The patient has been deemed qualified to consent to his/her own health care services. Emancipation or legal exceptions have been established based on the following:
____ Emancipation, self-supporting, free or parental care, custody and control
____ Married, or previously married minor
____ Family Planning Services
____ Diagnosis/treatment for venereal disease
____ Under the influence of a dangerous drug or narcotic
____ Meets mature minor criteria
____ Other (explain): _____
Clinician's Name: _____ Signature: _____ Date: _____
Patient's Name: _____ Signature: _____ Date: _____

3) Due to the following situation, administrative/legal approval has been obtained for _____ (treatment/procedure), by _____, Administrator.
____ Unavailable parents/guardian
____Abandoned Minor

4) Telephone Consent
1. Consent by telephone may be obtained when prompt treatment is needed or desirable if an adult patient is unable to give consent, or the patient is a minor.
2. Telephone consents require two witnesses.
3. Whenever possible, telephone consent should be follow up with a signature or fax. The fax should be attached.
Name _____Relationship: _____ Date: _____
Telephone #: _____
Witness' Name: _____ Signature: _____ Date: _____
Witness' Name: _____ Signature: _____ Date: _____