Care of Unaccompanied Minor: Consent to Treat

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal decision maker cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child. Be advised that protected patient health information may be shared with the designated decision maker to facilitate informed decision making.

AUTHORIZATION

I *(we)* have the legal right to preauthorize this facility to deliver medical treatment to my *(our)* child. I *(we)* request and authorize Family Healthcare and its personnel to deliver medical care to my *(our)* child listed below:

Name of Minor: _____

Date of Birth: _____

Medications: _____

Allergies: _____

Pertinent Medical History: _____

LIMITATIONS

Identify the type of medical services for which this authorization is *not* given: _____

_____

Identify the time frame for this authorization: From _____ Through _____
(This consent will be valid for one year from date of signature unless stated differently.)

I understand I may revoke this consent at any time in writing to Family Healthcare.

CONTACT INFORMATION

IF urgent medical care is needed, first try to contact me *(us)* regarding the health care of my *(our)* child at the following telephone number*(s)*. If you are unable for any reason to contact me *(us)*, then you may rely on the designated decision maker for consent.

Parent's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

_____
(Signature of Parent or Legal Guardian)

Parent's Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

_____
(Signature of Parent or Legal Guardian)