Treatment of a Minor

To All Parents:

We are required to obtain parents' consent to treat a child (unless a matter of life or death). It is requested that you complete the information below so that if your child presents to the One to One Health Clinic either alone or in the company of an adult (not legal guardian) for an office visit, this will allow the One to One Health medical staff to assess and threat the child as necessary. This consent is valid for 6 months. You will be required to sign another consent if the previous consent form has expired.

Minors Name: _____ DOB: _____ Sex: M or F (circle)

Mothers Name: _____ DOB: _____

Mothers Home Address: _____

Home #: _____ Cell #: _____ Work #: _____

Fathers Name: _____ DOB: _____

Fathers Home Address: _____

Home #: _____ Cell #: _____ Work #: _____

Additional Contact: _____

Relationship to Minor: _____ Phone #: _____

Allergies (minor or child): _____

Consent Statement Authorizing Treatment:

I hereby attest that I am a legal guardian of _____ and hereby give my consent for _____ to be evaluated and treated by the One to One Health Clinic without me being present.

Parent/Guardian Signature: _____ Date: _____

Minor Signature (to allow the parent/guardian to discuss details of the office visit):
_____ Date: _____

Parent/Guardian: Please provide a contact number for the provider to contact you between the hours of ____ and ____ to discuss the office visit of the above named minor.

Witness Signature: _____ Date: _____