MUNSON HEALTHCARE

MEDICAL CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR

_____ _____

Patient/Child Name **Date of Birth**

Unaccompanied Child

Many times parents will send children who are old enough to drive to the clinic without the parent or legal guardian present. If your child does now, or will be coming to the clinic by themselves in the future, please sign the consent below.

Failure to have consent on file except in emergency situations may delay treatment while we attempt to obtain your consent.

I, the undersigned, as the parent or legal guardian of the child identified above hereby authorize such diagnostic and/or medical treatment as may be considered necessary or appropriate under the circumstances by my child's attending provider. I understand the attending provider may also elect to delay certain diagnostic or medical treatment until a time that a parent/guardian is able to be present.

This consent expires in 1 year unless revoked in writing. As parent/legal guardian, I give consent for my child to be treated if I have not accompanied him/her. I understand that all services will be billed to my insurance and I will be responsible for all charges not covered by insurance.

_____ _____ _____

Signature of Parent/Guardian **Date** **Time**

Phone number where parent/guardian may be reached during appointment: _____

_____ _____

Printed Name **Relationship**