Parent/Guardian Consent to Treat Minor Patients

Today's Date

Patient Name:	Date of office visit:
DOB: Age: Sex:	Occupation:
Address:	Home phone:
City:	Cell phone:
State: Zip Code:	Primary Care Physician:
E-mail:	MRN:

ACCOMPANIMENT

I, the Legal Guardian of the minor child(ren) ______________________ give my
(Print minor child(ren') name)

consent for ______________________ to be accompanied by the individuals listed
(Print minor child(ren') name)
below to office visits and treatment that requires only general consent. I have already signed the general consent form.

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

Name ______________________ Relationship ______________________

NO ACCOMPANIMENT

Please complete this section ONLY if you consent for your minor child to transport himself/herself to office visits and treatment that requires only general consent.

My minor child(ren) ______________________ has my permission to transport
(Print name of minor child(ren))

himself/herself to receive general treatment that does not require general consent which I

______________________ as guardian, have already given.
(Print name of legal guardian)

SIGNATURE

You can contact me by phone:

Home: ____________ Cell: ____________ Work: ____________

I understand that this consent is in place until revoked by me and/or the expiration of one year.

Legal Guardian Signature ______________________ Relationship of legal guardian to child(ren) ______________ Date ________