I give consent for_____ to receive routine medical care,
(Child's name)
including health supervision visits, immunizations, and treatment of ordinary illness in my absence.

Select either A or B:

A. My child will be accompanied to his/her visit(s)

by _____ _____ _____
(Name of chaperone) (Name of chaperone) (Name of chaperone)

_____ _____ _____
(Relationship to child) (Relationship to child) (Relationship to child)

The chaperone above has my permission to sign the consent for any required immunizations and/or to accept medical advice, medications, and other information on my behalf.

B. My child is 16 years of age or older, and will be coming to his/her visits without a chaperone. My child has my permission to sign the consent for any required immunizations and/or accept medical advice, medications, and other information on my behalf.

Patient_____ _____ _____ _____
(signature) (printed name) (date) (time)

Office Coordinator_____ _____ _____ _____
(signature) (printed name) (date) (time)

PINNACLEHEALTH Hospitals

CONSENT FOR TREATMENT OF A MINOR

2000

Patient Identification

Patient Name: _____

MR Number: _____

Date of Birth: _____