BIGHORN
PEDIATRICS & FAMILY MEDICINE

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www.bighornfamilymed.com

CONSENT TO MEDICAL TREATMENT OF A MINOR
(WHEN PARENT OR GUARDIAN IS NOT PRESENT)

Designation of Alternative Individual to Consent to Medical Services

I hereby state that I am the natural parent or legal guardian with legal custody of the named minor and that I am authorized to consent to medical services on the minor's behalf.

PATIENT NAME:_____ DOB:_____

I hereby designate the following individual(s) to consent to medical services described below to be performed under the supervision and on the advice of the physician when the need for such services is clear and efforts to contact me or any other authorized parent or legal guardian are unsuccessful:

Individual(s) Designated to Consent to Medical Services:

Name_____ Relationship to Patient_____

Address: _____ City _____ State ____ Zip _____

Phone: _____

Name_____ Relationship to Patient_____

Address: _____ City _____ State ____ Zip _____

Phone: _____

I give permission for the receipt and request the following information:

____ Full medical history
____ Immunization history
____ Medical Records

I give permission for patient treatment and care as follows:

____ May bring child to appointment
____ May ask questions regarding a healthcare plan
____ May seek medical treatment

Parent/Guardian Signature _____ Date _____

Printed Name _____