



## 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 treat 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: \_\_\_\_\_