Consent to Treat a Minor

Patient Name: ________________________________

Date of Birth: __________________________________

In the absence of a parent or legal guardian I;

☐ DO

☐ DO NOT

Give permission for the above names minor child to be seen and treated by the providers of Skyview Family Medicine. This permission shall remain in effect until such time as the minor child becomes 18 years of age or I revoke permission in writing and the revocation is received by Skyview Family Medicine. I understand that failure to give consent may result in refusal to see my child in the absence of a parents or legal guardian.

____

Parent/ Legal Guardian

____

Date