

Minor Consent to Treat

I, (parent/legal guardian) _____, am unable to
accompany my child (child's name) _____, to
Capstone Clinic for his/her appointment.

Therefore, I give permission as follows (check one or both):

I give permission for (adult's name) _____ to accompany my child to seek treatment by any means necessary and provide consent for such treatment in my absence.

I give permission for (child's name) _____ to seek medical treatment without being accompanied by a parent, guardian, or other authorized adult.

Patients name _____ Date of Birth _____

Allergies _____

Insurance Carrier _____ Policy number _____

Expiration of Permission:

This form is **VALID ONLY** during the following timeframe:

Effective date: _____ / Expiration date: _____

I agree to be financially responsible for the cost of any medical care provided to my child under this Authorization.

X _____ (Name of parent/legal guardian) _____ (Date)

X _____ (Signature of parent/legal guardian) _____ (Date)

Witness signature _____ Date _____