New Smyrna Wellness Center

CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

In order for us to treat a minor without parent/legal guardian present, please complete this form:

I, _____ give permission for my child to be medically evaluated and treated at New Smyrna Wellness Center in my absence. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood tests) in the course of evaluation. I accept responsibility for physician and laboratory fees.

This consent applies to:

1. Complete physician check-up (including blood and urine samples)
2. Hearing, vision, scoliosis, and blood pressure screening
3. Immunizations
4. First aid and emergency care
5. Prescription and treatment for illness
6. Referrals to outside agency (for example: hospital, radiology) for services not provided at this office.

If there are any services that you do not consent to in your absence, please list:

_____

_____

My child will be accompanied by:

( ) himself/herself

( ) babysitter (name)_____

( ) other (name, relationship)_____

I give permission for the provider to share any relevant health information with the person who is accompanying my child.

Childs Full Name _____ Date of Birth _____

Parent or Guardian Signature _____

Parent/Guardian Name Printed _____

Parent/Guardian Phone number _____ Date _____

Employees Initials _____

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