University Hospitals

NAME OF OFFICE PRACTICE: _____

PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

ACCOMPANIMENT

I, the Legal Guardian of the minor child(ren) _____
(Print minor child(rens') name)

_____ give my consent for _____ to be
(Date of Birth) (Print minor child(rens' name)

accompanied by the individuals listed below to office visits and treatment that requires only general consent. I have already signed the general consent form.

This would include all In-Office lab tests and any vaccinations needed_____(parents initials)

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

NO ACCOMPANIMENT

Please complete this section <u>ONLY</u> if you consent for your minor child to transport himself/herself to office visits and treatment that requires only general consent.

My minor child(ren) _____ _____ has my permission to
(Print name of minor child(ren)) (Date of Birth

transport himself/herself to receive general treatment that does not require general consent which I

_____ as guardian, have already given.
(Print name of legal guardian)

SIGNATURE

You can contact me by phone:

Home: _____ Cell: _____ Work: _____

I understand that this consent is in place until revoked by me and/or the expiration of one year.

_____ _____ _____
Legal Guardian Signature Relationship of legal guardian to child(ren) Date