



Norman Blum, M.D.  
Danine Fruge, M.D.  
Maurice Laszlo, M.D.

Yanelis Martin, M.D.  
Ronald J. Scheib, M.D.

---

## MINOR RELEASE AND CONSENT

### General Release

As the parent/legal guardian of \_\_\_\_\_ (the "CHILD"), I assume the risk with respect to the CHILD's visit to Florida Pritikin Center, LLC ("Pritikin"). I release all rights and claims for damages which the CHILD and the CHILD's heirs, executors, and administrators, or I may have against Pritikin, its employees, directors, officers, consultants, agents, members, contractors or representatives for injuries or damages that occur as a result of the CHILD's visit to Pritikin.

### Consent

I voluntarily consent to and authorize the healthcare providers of Pritikin, including physicians, midlevel providers (including but not limited to Physician Assistants, Exercise Physiologists, Nutritionists, and Psychologists) paramedics and nurses, as applicable, to provide health care services to the CHILD as part of participation in Pritikin's programs. The health care services may include, without limitation, routine physical and mental assessment, nutritional analysis and recommendation, diagnostic and monitoring tests and procedures, examinations and medical treatment, routine laboratory procedures and tests (such as blood, urine and other studies), x-rays and other imaging studies, heart tracing (EKG), administration of medications, as well as other procedures and treatment prescribed by Pritikin's medical staff. I understand that no warranty or guarantee has been made to me with respect to care to be provided. I realize that there may be risks and hazards related to the performance of any planned care for the CHILD. I have been given an opportunity to ask questions about the CHILD's condition, treatment options, risk of treatment, risks of non-treatment, procedures to be used, and I believe that I have sufficient information to give this informed consent. I certify that this form has been fully explained to me, that I have read it or have had it read to me, that any blank spaces have been filled in, and that I understand its contents. I understand that signing this Minor Release and Consent form is voluntary and that I may refuse to sign it. However, I understand that if I do not sign this Minor Release and Consent form, that the CHILD may not be permitted on Pritikin's premises. I acknowledge that I have carefully read and understand the information presented to me. I understand that I may be asked to sign a separate informed consent form for certain treatments that require a separate informed consent form. I release Pritikin from responsibilities and liabilities while the CHILD is away from the Pritikin premises for any reason, including hospital-based procedures.

I hereby give my consent for the CHILD to be treated by and admitted to any hospital or medical facility for diagnosis and treatment if necessary. I request and authorize physicians, nurses, dentists and other medical staff from that hospital or medical facility to perform any diagnostic, treatment, and/or operative health care procedures that are medically necessary to the CHILD.

**NAME:**

I hereby accept financial responsibility for any and all medically necessary treatment administered to the CHILD in the event of an accident, injury, sickness, etc. to the same extent as if I had personally contracted for such care and services and agree to pay all such charges.

These powers shall be effectively immediately and shall not terminate unless revoked by me in writing with notice to all interested parties.

**HIPAA Authorization**

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as the parent/legal guardian of the CHILD, I am the CHILD's personal representative. In that capacity, I appoint and designate \_\_\_\_\_ (the "Guardian") as the CHILD's personal representative during the CHILD's visit to Pritikin. The Guardian shall have the status, power, authority and rights as the CHILD's personal representative for all purposes as provided under HIPAA.

**Medical Information**

The CHILD's date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

The following is a list of known allergies and allergies to medications of the CHILD: \_\_\_\_\_

The CHILD has the following known medical conditions: \_\_\_\_\_

The CHILD will be bringing the following prescriptions or medications: \_\_\_\_\_

**Background Information**

Family Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Names of Parents/Guardians: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Other) \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy or Group Number: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_