Methodist

EXPRESS CONSENT TO PROVIDE HEALTH CARE TO MINOR CHILD BY THE MINOR CHILD'S PARENT OR LEGAL GUARDIAN

Illinois law generally provides that only the parent or guardian of a minor child under the age of 18 may consent to medical treatment for that minor. Unless otherwise permissible under applicable law, it is the policy of Methodist Medical Group not to treat minor children unless they are accompanied by a parent or legal guardian.*

If, at any time in the future, you think you will be sending your minor child to the Methodist Medical Group for minor medical treatment without being accompanied by a parent or legal guardian, the Methodist Medical Group requires the following authorization to treat the minor child on record ***prior to*** that medical treatment being provided.

EXPRESS CONSENT TO PROVIDE HEALTH CARE AND TREATMENT TO MINOR CHILD:

I,_____, of _____ County, State of Illinois, am the Parent or Legal Guardian of _____, a minor child, age _____, born on _____. I hereby authorize my child's primary care physician or any member of the Methodist Medical Group, to treat said minor child even though I will not be present during the minor child's visit with the provider.

Furthermore, I authorize the above-mentioned provider to perform any acts that may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power to authorize any health care, x-ray examination, treatment and/or injections.

This consent shall be effective from the date it is executed until the date I terminate it in writing or at such time that the minor turns eighteen (18) or otherwise becomes emancipated.

By signing below, I certify and affirm: (a) I am the parent or legal guardian of the above listed minor child; (b) I have the understanding and capacity to recognize the importance of, to communicate, and to assign the health care decisions covered by this document; (c) I am fully informed as to the contents of this document; (d) I understand the full scope and importance of this grant of powers to the Methodist Medical Group to provide medical treatment to the above-listed minor child; and (e) I acknowledge and agree that I will be fully financially responsible for any and all medical costs incurred for the treatment provided to the above-listed minor child.

_____ _____
Parent/Guardian Signature Today's Date/Time

_____ _____
Parent/Guardian Name Printed Primary Phone Number(s)

**A separate form is required for each minor child. Minors who are emancipated under Illinois law are required to provide proof of emancipation before signing their own consent forms.*