

PERMISSION TO TREAT A MINOR WITHOUT A PARENT/GUARDIAN PRESENT

Brickie Community Health Clinic (BCHC) must receive permission from the student’s parent or legal guardian before providing treatment for an injury or illness that is not life-threatening. This form gives our healthcare providers your consent to assess and treat your student without an accompanying adult present.

I (we) do hereby state that I am (we are) the parent(s) and/or legal guardian(s) of the minor child named below, who resides with me (us) at the address indicated. Under the advice and care of a BCHC physician or advance practice nurse provider who is licensed to practice in the state of Indiana, I (we) consent to any necessary examination, diagnostic testing, or treatment for my (our) below named child.

Specifically, I (we) consent to each of the services below (initial each service that your child may receive from BCHC without your presence):

- Physical examination and/or first aid treatment
- Medical and nursing management of acute or chronic illnesses or diseases
- Immunizations required for school attendance or recommended flu shots
- Mental health screenings
- Substance abuse screenings
- Mental health counseling
- Sports physicals
- Nutritional counseling
- Pregnancy testing and counseling
- Testing and treatment for sexually transmitted diseases
- Laboratory testing: including blood sugar, mononucleosis and strep tests

Parent/Legal Guardian Name(s):

Minor Child’s Name:

Date of Birth: _____ **Age:** _____

Resides at (street address):

City/State/Zip Code:

**Parent/Legal Guardian Signature
Minor**

Date

Relationship to

**Parent/Legal Guardian Signature
Minor**

Date

Relationship to

This form gives our healthcare providers your consent to assess and treat your high school student without an accompanying adult present. This form and your consent shall be effective from August __, 201__ until September 1, 201__