920 Ironwood Drive, Suite 101
Coeur d' Alene, ID 83814
(208) 667-4557
(208) 765-2887 Fax

Consent to Treat a Minor without Parent/Guardian

I, _____, the parent or legal guardian of my child, _____, date of birth _____, authorize and consent Ironwood Family Practice to provide routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization is given in advance of any specific treatment being required, and I waive my right of prior informed consent to such treatment. This authorization is in effect until revoked in writing by me.

Signature of Parent/Guardian: _____ Date: _____

Phone Number: _____