DOC TYPE

Patient Name: _____

Date of Birth: _____

CONSENT FOR TREATMENT OF MINOR CHILDREN

1. **<u>ACCOMPANIED</u> MINOR**:

I, _____ authorize The Vancouver Clinic to treat my minor child, _____ for routine and emergency medical treatment when deemed necessary by qualified medical personnel when accompanied by the following (list names):

_____ _____ _____

2. **<u>UNACCOMPANIED</u> MINOR**:

I, _____ authorize The Vancouver Clinic to treat my minor child, _____ when unaccompanied, for routine, and emergency medical treatment.

EXCLUSIONS: Minor medical procedures (i.e. wart, mole, or toenail removal, etc.).

<u>If your child will be receiving immunizations during the visit</u> – in addition to this form, you will also need to fill out the Child and Teen Immunization Screening Form.

- ***One screening form is required for each immunization visit, every time immunizations are given.***
- **I UNDERSTAND** that both the **Unaccompanied Minor Authorization**, and the **Child and Teen Immunization Screening Form** are ***<u>required</u>*** in order to administer immunizations to an unaccompanied minor.

This authorization will automatically expire in one year from date signed, unless you wish it to expire sooner. If so, enter date: _____ / _____ / _____.

- **I UNDERSTAND** I must have an existing, valid phone number on file in my minor child's chart for verification purposes.
- **I UNDERSTAND** that I can select either or both of the options listed above.
- **I UNDERSTAND** that I may revoke this request in writing. If revoked, it would not affect any actions already taken by The Vancouver Clinic based upon this authorization.

_____
Printed name of parent/legal guardian

_____ _____
Signature of parent/legal guardian Date

For internal use only:

_____ Verified with parent/legal guardian in person or on the phone	_____ Staff Initials	_____ Date