



CONSENT TO TREAT MINOR FORM

This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services at Kids First Immediate Care or Red Cedar Valley Medicine, PLC.

Authorization:

I hereby appoint:

Name

Relationship

I hereby appoint:

Name

Relationship

I hereby appoint:

Name

Relationship

- Check here if you authorize any adult, including a stepparent, accompanying the child to be a decision maker who may consent to and authorize medical care, treatment or services for and to be involved in, the care of a minor child.

As a decision maker to consent to and authorize routine health care treatment and services for my child listed below.

I understand medical care, treatment and services may include, but are not limited to: medical evaluation, physical exam, immunizations, x-rays, and diagnostic lab work. I hereby empower and grant the decision maker(s) appointed above, permission to consent to and authorize medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. (Complete a separate form for each child.) I further understand that if transfer of my child to a hospital or emergency room is necessary, I authorize the decision maker(s) appointed above to consent for the hospital or emergency room treatment for my child in my absence.

Child's Name

Date of Birth

Parental contact information for questions regarding treatment:

Parent / Guardian's Name

Parent / Guardian's Name

Daytime Phone

Daytime Phone

Evening Phone

Evening Phone

Cell Phone

Cell Phone

I understand there is no obligation to contact me if the decision maker consents to the care. The individual appointed as decision maker herein is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Kids First Immediate Care or Red Cedar Valley Medicine, PLC. (Only one parent's signature is required.)

Signature of Parent of Legal Guardian

Witness

Date

Date