Consent to and Direction for Treatment of Minor

everside HEALTH

Minor Patient Information

Last Name:*	Legal First Name:*	M.I.:

Date of Birth (mm/dd/yyyy):*

1 1. Authorization and Consent. I (We), being the parent(s) or guardian(s), entitled to the care, custody and control of the above minor, do hereby authorize, request and direct you and each of you to render such treatment to said minor, including without limitation diagnostic, medical, minor procedures, x-rays, and venipuncture.

1.2 Unaccompanied by Parent/Guardian. This consent to treatment is given in contemplation that the above minor may from time to time appear at Everside Health locations, or engage in a virtual care visit, for examination or treatment or both, unaccompanied by an adult, custodial parent or non-custodial parent, because of my (our) absence or unavailability. I (We) hereby authorize, request and direct you to render treatment to said unaccompanied minor, including without limitation diagnostic, medical, minor surgical care, x-rays, venipuncture, immunizations to the extent I (we) have previously consented to the immunizations, and other care that requires a series of treatments to the extent I (we) have previously consented to the series of treatments. Specifically, I approve:

☐ All non-emergent, non-major care, including immunizations rendered at Everside Health

☐ Limited treatment, condition(s), procedure(s), and/or treatment(s) (e.g., well-child check-up, dental cleaning and examination, x-ray, venipuncture, etc.) as listed here:

_____

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☐ Please contact me (us) in the event a medical decision needs to be made for additional, unanticipated medical services beyond the reason for the patient's visit.

1.3 Parent/Guardian Participation. I (We) understand that at times the providers may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purposes of assisting in the diagnosis or treatment. I (We) agree to cooperate by being present with said minor at all times possible or when requested.

1.4 Expiration or Termination. All aspects of this consent will be in effect until specifically terminated or modified by written notice received by Member Services, or on the date the minor becomes an adult under state law.

Signature of Patient or Legal Guardian	Relationship to Minor
Date	Time

Note to parent or guardian: This form should be completed for each minor in the family.

**Required information*