COLLEGE STATION FAMILY MEDICINE CENTER

CONSENT TO MEDICAL TREATMENT FOR MINORS

Minor Information

Patient Name:	Patient DOB:

Parent/Legal Guardian Information

Name:	Relationship to Patient:
DOB:	SSN:
Cell Phone:	Work Phone:

Special Permissions

_____ (Initials) Unaccompanied: I grant permission to treat and provide any healthcare services to my child that the provider deems necessary for treatment, if my child arrives at the office unaccompanied.

_____ (Initials): Accompanied by Others: If I am unable to accompany my child to the appointment, the below listed individuals have my permission to accompany my child and make medical decisions regarding my child.

Other Adult Individuals Allowed to Accompany Minor

Name:	Phone #:	Relationship to Patient:
Name:	Phone #:	Relationship to Patient:
Name:	Phone #:	Relationship to Patient:

I authorize College Station Family Medicine Center to treat and provide any healthcare services to my child deemed necessary for treatment and/or diagnosis. I also understand that, in the course of treatment, photographs may be taken for clinical or educational purposes. I acknowledge that this consent will remain in effect until I revoke it in writing and present the notice to the office or the minor reaches the age of 18 years.

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

Parent/Legal Guardian: _____ Date: _____