WESTERN WISCONSIN HEALTH

# Minor Consent to Treat

Name of Minor Child: _____ DOB: _____

Parent/Guardian Name: _____

Address: _____ City: _____ ZIP: _____

Phone: _____

If the minor child noted above seeks treatment at Western Wisconsin Health unaccompanied, I as the parent/guardian, grant authorization to Western Wisconsin Health staff to provide ambulatory medical care that is in my child's best interest. Examples include, but are not limited to immunizations, medical exams and treatment, physicals, physical therapy, etc.

In addition, I recognize that in my absence, the following individuals might accompany my child and I authorize them to provide verbal/written consent.

This authorization is valid from _____ to _____.

Name of Individual(s) authorized to consent for care:

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

_____ _____
**Parent/Guardian or Legal Representative Signature** **Date / Time**

Please Place a Current Admission Sticker Here When Available

Patient Name: _____

Date of Birth: _____Med Rec #: _____