DAYSPRING FAMILY MEDICINE

AUTHORIZATION FOR TREATMENT OF A MINOR

I give permission for mu child to be medically evaluated and treated at Dayspring Family Medicine in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

This consent applies to:

- Complete physician check-up (including blood and urine samples)
- Hearing, vision and blood pressure screening
- Immunizations
- First aid and emergency care
- Prescription and treatment for illness
- Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

If there are any services that you do not consent to in your absence, please list:

_____

_____

_____

_____

My child will be accompanied by:

__ himself/herself

__ babysitter (name) _____

__ other (name, relationship) _____

I give permission for the physician to share any relevant health information with the person who is accompanying my child.

_____

Child's Name and Date of Birth

_____

Parent or Guardian Name and Signature

_____

Phone number to reach Parent or Guardian