ARCHANGEL MICHAEL HEALTH, PA

Consent to Treat a Minor

Phone: (352) 441-9110
Fax: (352) 441-9110

1. Patient (Minor) Information

Full Name of Minor:

Date of Birth (MM/DD/YYYY):

Home Address:

City, State, ZIP:

2. Parent/Legal Guardian Information

Name of Parent/Legal Guardian:

Relationship to Minor (e.g., mother, father, legal guardian):

Phone Numbers:

Home:

Cell:

Email (optional):

Address (if different from Minor):

City, State, ZIP:

3. Authorization for Medical Evaluation & Treatment

I, the undersigned parent or legal guardian, hereby authorize Archangel Michael Health, PA and its healthcare providers to perform medical examinations, evaluations, and treatments deemed necessary for my minor child named above. This includes, but is not limited to:

- Telehealth consultations (where applicable)
- Routine medical examinations
- Diagnostic procedures (e.g., lab tests, imaging)
- Prescription or medication administration (as permitted by the practice)
- Other non-emergency healthcare procedures deemed necessary by the provider

In the event of an urgent or emergency situation when I am not present, I consent to such care and treatment as may be necessary to stabilize and protect the health of my child until I can be contacted for further instructions.

4. Limitations or Special Instructions

> If there are certain treatments or procedures you do not authorize or any special instructions the healthcare provider should be aware of, please indicate them below:

5. Duration of Consent

> This consent remains in effect until revoked in writing by the undersigned or until the minor reaches the age of 18, whichever occurs first, unless an earlier expiration date is specified:

Expiration Date (optional):

6. Acknowledgment & Signature

> By signing below, I acknowledge that I have read, understand, and agree to the terms of this Consent to Treat a Minor. I also affirm that I have the legal right to consent to medical treatment for the minor named above.

Signature of Parent/Legal Guardian:

Printed Name:

Date (MM/DD/YYYY):

If signed by a legal guardian other than a parent, please attach documentation confirming legal guardianship.

Thank you for trusting Archangel Michael Health, PA with your child's healthcare needs.

If you have any questions or need to update this consent, please contact our office:

Archangel Michael Health, PA
Phone: (352) 441-9110
Fax: (352) 441-9114