

Millennial Medical Clinic

Consent to Treatment of a Minor When Parents/Guardians are Temporarily Unavailable

Patient Name: _____ **DOB:** _____

- I give permission to the medical staff of Millennial Medical Clinic to treat my child in my absence.
- I authorize any medical treatment necessary in my absence and in the event of an emergency for the well-being of the minor mentioned above.
- It is understood that this consent is given before any specific diagnosis or treatment and allows the physician to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who can consent to treatment (please print):

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

Name: _____ Relationship to Child: _____ Phone: _____

I give permission for _____ (child's name), who is 16 years or older, to be treated unaccompanied. In the event the provider needs to speak with me, I can be reached at (phone number) _____.

2. Medical concerns: _____

3. Known allergies: _____

4. Medications: _____

Name of Parent/Legal Guardian* (Print): _____

Relationship to Child: _____ Contact Number(s): _____

Address: _____

*If Power of Attorney is required to show legal guardianship, you will be required to show Power of Attorney paperwork.

This Consent is effective until withdrawn in writing by the child's parent or guardian or until the child turns 18. I understand that I am responsible for notifying Millennial Medical Clinic of any changes.

Signature: _____ **Date:** _____