Morehead Primary Care

333 Beacon Hill Road,Suite 201
Morehead, KY 40351

phone: (606) 780-0444
fax: (606) 784-2344

Consent for Treatment of a Minor without Parent Present

I give permission in my absence to be medically evaluated and treated at Morehead Primary Care. I understand that it may be necessary to perform diagnostic tests (blood, strep screen, flu screen etc.) in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

Insurance__________________________ ID________________________________

This consent applies to:

1. Complete physician check up
2. Hearing, vision, and blood pressure screening
3. Immunizations
4. First aid and emergency care
5. Prescription and treatment for illness
6. Referrals to outside agency (hospital, radiology etc.) 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____________________ for a period of __________-_________.

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

____

Child's Name Date of Birth Today's Date

____

Parent/Guardian Name Signature Phone

Ad Majorem Dei Gloriam

Christian Weigel, MD
Angela Pannuti, PA-C
Lauren Hamilton, PA-C
Nancy Weigel, MD
Christie Conn, PA-C
Sylvia Southworth, PA-C