333 Beacon Hill Road,Suite 201
Morehead, KY 40351

phone: (606) 780-0444
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CONSENT TO TREAT MINOR CHILDREN

Patient's Full Name ______________________________ **Date of Birth** ___________________

I, _______________________, parent or legal guardian of ___________________, born the _________ day of ________________, 20______ do hereby consent 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.)

This authorization is effective from the _________ day of ___________________, 20______

to ________ day of _________________, 20______.

I accept responsibility for physician charges and laboratory fees.

Insurance___________________________ ID__________________________________

This consent applies to:

- Complete checkup and/or exam
- Hearing, vision, and blood pressure screening
- Immunizations
- First aid and emergency care
- Prescription and treatment for illness
- 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:____

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

______________________________ ______________________________ _______________

Signature of Parent/Guardian Relationship to Patient Date

____

Phone number of Parent/Guardian