

**Treatment Authorization for Minor**

**Minor Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient at:**  Medical  Mental Health/Substance Abuse  Eye Care

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

I grant authorization and consent for the below listed individual(s) to authorize Salina Family Healthcare Center staff to provide medical, dental, eye care, and or mental health or substance abuse treatment to the above named minor.

Services may include, but are not limited to examination; preventative and/or curative treatment; x-rays; laboratory services; medical and surgical diagnosis; preventative, diagnostic, restorative, or oral surgery (including extractions); vaccinations; therapeutic injections; allergy injections; local anesthetic; mental health/substance abuse intake, diagnosis, treatment plan, sessions; and any consultation deemed necessary at the provider’s discretion.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required and is given to provide consent to treatment in my absence or incapacitation.

List name(s) of individuals over 18 years old who you give authorization to consent for medical/behavioral health/eye care treatment of the minor child.

1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***The adult accompanying the minor child must have a current, reliable method of contacting the parent/legal guardian if needed.***

 My adolescent child is years old and I consent to my child attending appointments without an adult present.

This consent shall remain in effect until revoked, in writing, by the parent(s) or legal guardian(s), or until the minor becomes able to consent to his/her own treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature Today’s Date

I confirm that I verified the identity of the parent/legal guardian and that the parent/legal guardian named above signed this document in my presence on the date listed below.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Today’s Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Today’s Date

*For official use only.* Scanned:  Medical  Eye Care