SALINA FAMILY HEALTHCARE CENTER

Medical 785-825-7251 | Dental 785-826-9017 | Pharmacy 785-452-3900 | Eye Care 785-823-3937

Treatment Authorization for Minor

Minor Name: _____ **DOB:** _____

Patient at: ☐ Medical ☐ Mental Health/Substance Abuse ☐ Eye Care ☐ Dental

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

STATE OF _____

COUNTY OF _____

SUBSCRIBED AND SWORN TO before me this _____ day of _____, 20___.

_____ _____

Notary Public Signature **Commission Expiration Date**

For official use only. Scanned: ☐ Medical ☐ Eye Care ☐ Dental