

# Authorization for Consent to Treat a Minor

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_

(name of person authorized to consent) to consent to obtain the following medical/dental treatment for \_\_\_\_\_ (name of minor).

Please check one:

- \_\_\_\_\_ all medical/dental treatment, OR
- \_\_\_\_\_ only the medical/dental treatment listed below (specify treatment):

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

The authorization shall be limited to the following time period:

\_\_\_\_\_

If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*(Must be signed by parent or legal guardian)*

## To be completed for each child

Child's birth date: \_\_\_\_\_

Name and phone number of child's physician:

\_\_\_\_\_

Address and phone number where parents or guardian can be reached (please include alternate cell phone numbers, if applicable):

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

Additional information that may be helpful in treating your child:

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

Child's medical history (list any chronic or existing diseases, medical problems, or known allergies):

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

Medications your child is currently taking (name, dosage, and frequency):

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

Child's dentist (name and phone number):

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

If the child has Medicaid or private insurance please include that information below.

Medicaid (please attach a copy of Medicaid card)

Medical/dental insurance company (attach a copy of insurance card):

\_\_\_\_\_

Policy holder name: \_\_\_\_\_

Policy holder D.O.B. \_\_\_\_\_

Policy holder S.S.N. \_\_\_\_\_

Policy holder ID: \_\_\_\_\_

Member's Employer: \_\_\_\_\_

Policy No.: \_\_\_\_\_

# Consent for Treatment of a Minor

Your Family's  
Healthcare  
Home



JORDAN VALLEY  
COMMUNITY HEALTH CENTER

It's important that your children are able to access non-emergent health care when you are away from them. As parents, we can't always be all of the places that we need to be at one time. For occasions when a relative, babysitter, or responsible adult is bringing your child into **Jordan Valley Community Health Center** for medical or dental care, you should provide written authorization for consent to treat a minor.

Unless a child's injuries are life-threatening, physicians and other providers are required by law to have permission from the parent (or legal guardian) before treating anyone under age 18.

If your children are with a relative or babysitter when you're away, you should provide written authorization for the adult to consent to treatment for your child during your absence. You can do this by filling out the attached form and asking the responsible adult to keep it on hand in case medical treatment is required. Please place the signed form with emergency numbers or other important items to have on hand. The signed form should be brought to Jordan Valley if your child needs medical treatment.

A separate authorization form is needed for each child. Additional copies of this authorization may be obtained from **Jordan Valley Community Health Center** at (417) 831-0150 or [www.jordanvalley.org](http://www.jordanvalley.org).

