SONORAN
MEDICAL CENTERS

Consent for Treatment of a Minor

I give permission for my child, _____, date of birth _____ to be medically evaluated and treated at Sonoran Medical Centers. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood test) in the course of the evaluation. I accept responsibility for provider charges and laboratory fees.

This consent applies to:

1. Complete provider check-up (including blood and urine samples)
2. Hearing, vision, and blood pressure screening
3. Immunizations (in addition to this form, parental/guardian consent for specific immunization would still be needed prior to injection)
4. First aid and emergency care
5. Prescription and treatment for illness
6. Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office

Mark **ONE** of these selections:

☐ **With Parent/Guardian Present** – restricted to medical care when parent or guardian is in office (excludes emergency care and items required under Arizona/Federal laws)

Names of Parent(s)/Guardian(s)_____

☐ **Without Parent/Guardian Present**

I give permission for my child to be medically evaluated and treated at Sonoran Medical Centers in my absence. My child will be accompanied by:

[ ] himself/ herself

[ ] babysitter (name) _____

[ ] other (name, relationship) _____

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

If there are any services that you do not consent to in your absence, please list:

_____

This consent will remain in effect until the patient's 18th birthday, until amended, or until revoked in writing (whichever is earlier).

_____ _____

Child's name *Today's Date*

_____ _____

Parent or Guardian Signature *Parent or Guardian Name*