EASTERN IOWA HEALTH CENTER

Consent to Treat Minor in Parental Absence

The purpose of this form is to obtain guidance from you, the patient's parent or legal guardian, to treat your child if your child requires routine or non-acute medical care while you are unable to attend or be reached. This form will be completed, signed by a parent or legal guardian and should be discussed with those below that would be caring for your child in your absence.

Anytime your child arrives at the clinic without you (the parent or legal guardian), we will first attempt to contact you to authorize the medical treatment. Below, indicate how we can contact you to authorize the medical treatment your child requires.

Child Name: _____ DOB: _____ Athena #: _____

Phone Consent:

Name 1: _____ Relationship to Patient: _____

Contact Numbers: Home: _____ Work: _____ Cell: _____

Name 2: _____ Relationship to Patient: _____

Contact Numbers: Home: _____ Work: _____ Cell: _____

If we are unable to reach you, we will proceed with the medical treatment with the authorization of the person(s) that you have listed below.

Authorized Persons:

Should my child require routine or non-acute medical care while I am unable to attend or be reached, I hereby authorize the person(s) below to consent to medical treatment while in the office.

Name: _____ Phone: _____ Relationship to Patient: _____

Name: _____ Phone: _____ Relationship to Patient: _____

This authorization shall remain effective until otherwise revoked by me in writing. I understand that it is my responsibility to update the above information if I want it changed. However, I may be asked to confirm the information with a new dated signature on an annual basis.

_____ _____

Signature of Parent/ Legal Guardian Date

Relationship to Patient: _____