



An Affiliate of **MERCYONE**

# PARENTAL CONSENT FOR TREATMENT OF A MINOR

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 the appointment or be reached by phone. 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 (if applicable). You can designate one or more individuals to accompany your child for services performed at the Kossuth Regional Health Center. Your child may also present for services unaccompanied if you choose.

*\*If the minor is a ward of the court and parental rights have been severed or amended, the representative of the agency responsible for the child must sign.*

Please note that parental consent is not necessary for all treatment services. Minors may provide consent for alcohol and substance abuse diagnosis and treatment; contraceptive services, or screening for HIV infection and other sexually transmitted diseases; donating blood if seventeen (17) years of age. Minors are entitled to confidentiality and control the release of treatment information in situations where minors may consent to their own treatment.

In the event that a life-threatening emergency exists, written parental consent will be obtained following treatment.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

As parent or guardian of (child's name) \_\_\_\_\_, I give consent for this child to be treated by Kossuth Regional Health Center in my absence.

My child may be (please make the appropriate choice/choices below):

Accompanied by: \_\_\_\_\_  
\_\_\_\_\_

Unaccompanied (may come to the clinic on their own)

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to Kossuth Regional Health Center and that updating the above information is my responsibility. I further understand that any such revocation does not apply to services performed from the date of signature to date of revocation.

Parent/guardian's name (print): \_\_\_\_\_

Parent/guardian's signature: \_\_\_\_\_

Date of signature: \_\_\_\_\_

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For Facility Use Only

Verbal authorization obtained by: \_\_\_\_\_ Date: \_\_\_\_\_

Verbal authorization obtained by: \_\_\_\_\_ Date: \_\_\_\_\_

Who authorized: \_\_\_\_\_

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Revocation Section

I hereby revoke this Minor Consent Form

Date: \_\_\_\_\_  
MM/DD/YYYY

\_\_\_\_\_  
Parent/guardian's Signature