**Permission to Treat a Minor without a Parent/Guardian present**

Comprehensive Women’s Healthcare must receive permission from a child’s parent or legal guardian before providing treatments for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany them to the clinic for treatment. If the party accompanying your child (baby-sitter, friend, relative, etc.) does not present this information the clinic will attempt to contact you to request written permission to treat your child.

 Please note:

* A parent/legal guardian must attend a minor’s first visit here at Comprehensive Women’s Healthcare
* Minors may not receive immunizations without a parent or legal guardian present.
* This “Permission to Treat a Minor” form is valid only for the dates listed below.
* In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of “heightened sensitivity” such as STD testing, family planning, mental health, etc.

**Patient name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I grant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (an adult into whose care the minor has been entrusted) to arrange for and authorize routine and emergency treatment at Comprehensive Women’s Healthcare for the following dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(these dates indicate when this form is valid)

**Please initial**:

[\_\_\_] We/I are authorizing the minor to seek and consent treatment with no adult present

[\_\_\_] We/I acknowledge that we are responsible for all reasonable charges in connection with the care and treatment rendered.

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

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please send the insurance card and co-pay (if applicable) to the appointment.

**In case of emergency, I can be reached at**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ home/cell/work (please circle)