CONSENT TO TREAT MINORS

Today's date: _____ Expires:_____

Patient Name: _____ DOB: _____

Name of parent or guardian authorizing treatment:

Name _____ Relationship: _____

I, _____, (parent or legal guardian) am authorizing and requesting, for the above-mentioned minor to receive medical treatment from Brehm Medical Center.

This authorization must be renewed one year from today.

I authorized these other individuals to accompany the above-mentioned minor to their appointment if I am not able to attend. Any authorized individuals listed below must bring a valid form of identification to the appointment.

Name _____ Relationship: _____

Name _____ Relationship: _____

Name _____ Relationship: _____

In case of an emergency I can be reached at the following phone numbers:

Work _____ Cell _____
Home _____ Other_____

_____ _____
Parent Signature Date

_____ _____
Witness Signature Date