

CONSENT TO TREATMENT OF A MINOR

MINORS AGE 15 AND UNDER:

Written consent from parent or legal guardian;
An adult must accompany the patient during the visit.

A Consent Form must be signed for each visit.

I, _____, authorize Keller Family Medical Center
(Parent/Legal Guardian Name)
to treat _____, my minor child on _____.
(Patient Name) (Date)

Symptoms patient is experiencing:

Phone number provider can contact you at if necessary _____

Signed _____ Date _____

MINORS AGE 16 AND 17:

Written consent from the parent or legal guardian

I, _____, authorize Keller Family Medical Center
(Parent/Legal Guardian Name)
to treat _____, my minor child on _____.
(Patient Name) (Date)

Phone number provider can contact you at if necessary _____

Signed _____ Date _____

All minors must be accompanied by their parent or legal guardian for immunizations, invasive procedures, lab draws or injections.