

PLACE LABEL HERE



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

DOB: \_\_\_\_\_ Med. Rec. Site: \_\_\_\_\_

MR #: \_\_\_\_\_

MINOR

**Permission to Authorize Routine Examination and Treatment of a Minor**

By checking this box, I revoke all previous *Permission to Authorize Routine Examination and Treatment of a Minor* forms.

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

I, \_\_\_\_\_ give permission to the adults below to go with my child to the Reliant Medical Group office without a parent/guardian. These adults can allow my child to have routine exams and treatment. This includes, but is not limited to, well visits and care for non-urgent medical problems.

**Approved Adult(s):**

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

Phone Number: ( ) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

Phone Number: ( ) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

Phone Number: ( ) \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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By checking this box, I am agreeing to let my child receive:

- Routine care and treatment with an approved adult present
- Routine care and treatment without a parent/guardian or approved adult present
- A vaccine with permission from the approved adult present

**NOT EFFECTIVE UNLESS SIGNED AND DATED**

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Office Use Only:**

Administrative: Consent Forms: Consent for Treatment MRN: \_\_\_\_\_