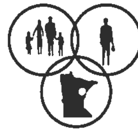

Parental / Guardian Consent to Treatment of a Minor

I hereby authorize the following individual(s):

	Name	Relation
1.	____________________________	__________________
2.	____________________________	__________________
3.	____________________________	__________________
4.	____________________________	__________________
5.	____________________________	__________________

to consent to care for my minor child at the Duluth Family Practice Center. This includes the diagnosis and treatment of illness, allergy treatments, and routine health care such as immunization procedures and physical examinations on the minor's behalf as is necessary for the minor's health and best interests.

I also authorize the above named person to act on my behalf in case the minor experiences a reaction to the authorized treatments or is a victim of injury or illness when immediate medical or surgical care is needed, provided diligent effort is made to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize the above named person to take such action and give such consent on the minor's behalf as that person's reasonable judgment dictates.

I understand that this consent will last for **one year** from the initial signed date unless I change my mind and withdraw my consent sooner in writing. If I withdraw consent, it will not affect actions already taken by the Duluth Family Practice Center.

Patient Name: ____________________________ **Date of Birth:** ______________

☐ **By checking this box, I consent that my child can be treated without a parent or guardian present at the time of visit only if the child is at least age 16**

____ __________________

Signature of Parent/Guardian Authorizing Treatment **Date**