Duluth Family Medicine Clinic

Minor Consent to be accompanied by others or to be unaccompanied
If over the age of 16

I hereby authorize the following individual(s):

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

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

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, provide diligent effort is made to notify me to the situation and obtain my preferences. If 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 Medicine Clinic. I also understand I will have to physically be present to sign the electronic GCA once yearly for all minor children.

☐ **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.**

Permission was obtained from: Name: _____
Relationship (circle one): Mom Dad Legal Guardian

Witness #1 _____

Witness # 2 _____

Patient Label