Sarah D. CULBERTSON Memorial Hospital

Community Medical Clinic (CMC) Rushville Family Practice (RFP) Elmer Hugh Taylor Clinic (EHTC)

Consent to Treat Minor - Without Parent/Legal Guardian Present for Routine Medical Care

Sarah D. Culbertson Memorial Hospital (CMH) and its clinics must receive permission from a child's parent or legal guardian prior to providing treatment for routine medical care and interventions which may include, but are not limited to: Medical evaluations, physical exams, routine immunizations, injections (including Allergy Injections), x-rays, lab work, (examples: throat or nasal swabs, blood draws, urine catheterizations, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations). This form provides the legal permission to (depending on the minor's age) either treat without an adult present (Section A), or with a designated adult present (Section B)

Patient's Name: _____ **DOB:** _____
Last First Middle

Allergies: _____

Current Medications: _____

Chronic Conditions: _____

Section A (ONLY for child at least 16, but not 18 years old)

Authorization to treat your minor child in case you or your designated representative is unable to accompany your child to one of his/her visits: I, (print your name) _____ grant CMH and its clinics permission to assess and treat the aforementioned minor without an adult present. I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

Section B (for child under 18 years old)

Delegation of authority for medical treatment of a minor child to the designated representative indicated below: I, (print your name) _____ grant CMH and its clinics permission to assess and treat the aforementioned minor in the presence of either of the following adults (you may choose more than one) either of whom is authorized to approve treatment:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

Note: A parent/legal guardian MUST be present for a minor patient's first visit with CMH and its clinics
This authorization is valid for: □ Date _____ **VALID FOR ONLY one visit**

Please Note: Insurance card(s) and co-pay amounts (if applicable) must be presented at each visit.

AUTHORIZED BY: _____ Date Signed: _____
Parent or Legal Guardian

Emergency Contact Phone #1 _____
Emergency Contact Phone #2 _____

(Note: In accordance with Illinois State Law 410 ILCS, minors may consent to certain medical treatment without obtaining consent of a parent or legal guardian).

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