Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

Minor Child Consent to Treat

Patient's name: ___________________________________ Date of Birth: _____________

I give my permission for my child to be medically evaluated and treated at Valley Professionals Community Health Center in my absence. In addition, I give permission for the provider to share any relevant health information with the person accompanying my child. My child will be accompanied by:

___ himself/herself (only if 16 years of age or older)

___ relative/family member

Name: _____________________________ Relationship: ____________________

___ other

Name: _____________________________ Relationship: ____________________

If I am unable to bring my child for treatment at Valley Professionals Community Health Center, the individuals listed above may bring in my child for treatment which may include:

- physical examinations including screenings such as vision and blood pressure
- immunizations
- blood and/or urine tests
- first aid and emergency care
- prescription and treatment for illness
- referrals to an outside facility for services not provided in office (i.e., radiology, specialty)

I understand that this consent is only available for one year from the date of signature. If changes are needed to be made to the list at any time during the year, it will be necessary to complete a new form.

Parent's signature: ____ Date: _______________

** Any person bringing a child in for treatment must bring in a picture ID (driver's license, state ID) so that we may keep a copy in the child's file.