Consent for Evaluation and Treatment of a Minor without Parent/ Legal Guardian Present

CMINOR

Use for minor coming alone (signed in advance)

I (full name) _____ having legal custody

of (full name) _____ whose birthday is _____,

give permission to HealthPartners family of care to provide routine medical care to my child while I am not present at the appointment. Routine medical care may include medical evaluation, physical exam, routine immunizations, injections (including allergy injections), x-rays, lab work (examples: throat or nasal swabs, blood draws, urine collection), wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations.

During the appointment, HealthPartners may (check all that apply):

☐ **Provide medical care and treatment for the conditions listed below:**

_____

_____

☐ **Administer routine immunizations:** ☐ Yes ☐ No

!	Prior to administering a vaccine, the clinic will call you to review the vaccine information statement and answer your questions. *You can find more information regarding vaccines and immunizations on the CDC website:* *https://www.cdc.gov/vaccines/hcp/current-vis/*

☐ **List any specific care or treatment you do not want your child to receive:**

_____

_____

I authorize HealthPartners to act on my behalf in case of an emergency. If this occurs, HealthPartners will make diligent efforts to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize HealthPartners to take appropriate and necessary actions to care for my child.

Signature of parent/guardian	Printed name	Date	Time

Use the backside of this form when a minor is accompanied by another adult.

Use for minor accompanied by another adult (signed in advance)

I (full name) _____ having legal custody

of (full name) _____ whose birthday is _____,

authorize the caregiver(s) listed below to accompany my child to clinic appointments, receive my child's medical information, and consent to routine medical care for my child. Routine medical care may include medical evaluation, physical exam, injections (including allergy injections), x-rays, lab work (examples: throat or nasal swabs, blood draws, urine collection), wart treatment with liquid nitrogen, minor burns, and minor suturing of lacerations.

Name of caregiver (print) _____ Phone number _____

Name of caregiver (print) _____ Phone number _____

Immunizations:
I authorize these caregivers to act on my behalf to review Vaccine Information Statements (VIS) and provide consent for administration of recommended vaccines. ☐ Yes ☐ No

Limitations:
List any specific care or treatment you do not want your child to receive:

_____

_____

_____

This consent is valid (check only one):

- ☐ For date of service (month/day/year): _____
- ☐ From (month/day/year): _____ until _____
- ☐ From date I sign this consent, until I either notify HealthPartners in writing that it is no longer in effect, or my child turns 18 years old, whichever occurs first.

Parent/guardian contact information for questions regarding treatment of the child:

Parent/guardian name	Phone number

By signing this consent, I agree that HealthPartners may disclose health information about my child to the listed caregiver(s) for the timeframe I indicated above. I also agree that I will be responsible for the charges that result from my child's care. I understand that I may revoke this consent by sending a written request for cancellation to the Park Nicollet/ HealthPartners clinic, and that the cancellation will take effect when HealthPartners receives my written notice.

Signature of parent/guardian	Printed name	Date	Time