CONSENT TO TREAT MINORS

I, _____, parent or legal guardian of_____, born.

the___ day of_____, 20___ do hereby consent to any medical care provided by a HHM Health's physician, nurse practitioner, physician assistant deemed to be necessary for the welfare of my child while said child is under the care of _____

_____ (name of school your child attends), and I am not reasonably available by telephone to give verbal consent or are unavailable to be present with my child during their medical visit.

I further give HHM Health's physicians, nurse practitioner, or physician assistants who may be caring for my child permission to call for emergency medical services if they believe my child need to be evaluated in a hospital.

This authorization is effective from the___ day of _____, 20___to

___day of _____, 20____

I have been given the opportunity to ask questions and understand the above statements.

_____

Name of Parent or Legal Guardian (please print)

_____ _____

Signature of Parent or Legal Guardian **Today's Date**

_____ _____

Witness's Name (please print) Today's Date

Witness's Signature: _____

This consent form should be taken to the medical clinic when the child is taken for treatment. This form will be kept on file by the health clinic for one academic year as defined by your school system. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Home Address_____

City: _____ State:_____ Zip:_____

PRIMARY PARENT/GUARDIAN Name: _____

Preferred contact method ☐Cell _____ ☐ Home phone _____

Email address:_____

I give permission to leave a voice mail on ☐ Cell or ☐ Home phone.

SECOND PARENT/GUARDIAN Name: _____

Preferred contact method ☐Cell _____ ☐ Home phone _____

Email address:_____

I give permission to leave a voice mail on ☐ Cell or ☐ Home phone.

Student's Phone Number (if applicable): _____

Emergency Contact Name: _____

Emergency Contact Telephone: _____☐ Cell or ☐ Home phone

Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Insurance Company Name: _____ Group Policy #_____

Member ID # _____

Primary Pediatrician: ☐ Yes or ☐ No

If Yes, Primary Pediatrician Name: _____

Primary Pediatrician Phone Number: _____

Primary Pediatrician Address: _____

_____

Preferred Hospital: _____