CHATTANOOGA FAMILY PRACTICE ASSOCIATES, PC

Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

The undersigned parent or legal guardian of _____ authorizes the
(Child's Name)
person(s) listed below to consent to treatment of the child, including but not limited to, emergency, x-ray, and aesthetic, or surgical services when I am not immediately available in person, or by telephone call to _____.
(Preferred Phone Number)

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

Name_____ Relationship to Child:_____Phone:_____

Name_____ Relationship to Child:_____Phone:_____

Name_____ Relationship to Child:_____Phone:_____

2. Medical concerns:_____

3. Known allergies:_____

Name of Parent or Legal Guardian:_____ Relationship to Child:_____
(Print Name)

Contact Number(s):_____

Address: _____ City, State, Zip:_____

****For Minors 15-18: I consent to allowing my minor to be seen without a parent or guardian**

☐ **Yes** ☐ **No Initial_____**

“By signing this Consent for Treatment, I consent and authorize treatment to my child based upon the consent of the designated persons on this form and acknowledge and accept financial responsibility for any treatment rendered pursuant to this authorized treatment.”

Signature:_____ Date:_____

This consent is effective until withdrawn in writing by the child’s parent or guardian.

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