Youens & Duchicela Clinic
FAMILY MEDICINE | BOARD CERTIFIED

# Consent of Medical Treatment for Minors

**I, _____ (Printed Name of Parent/Legal Guardian) of**

**_____ (Printed Name of Patient/Minor) Date of Birth: _____,**

give my written consent for the following adult/responsible representative to bring in my child to be seen by one of the doctors at Youens & Duchicela Clinic to receive medical attention. I authorize and appoint **_____(name of person given consent to)** to act in my behalf as my agent to consent to medical treatment of the minor when I cannot be contacted to give consent to such medical treatment to include, without limitation; X-ray examination, anesthetic treatment, medical, dental, surgical examination or treatment, and general hospital care. No prior determination of life-threatening emergency or danger of serious or permanent injury resulting from delay of treatment need be made under this authorization.

I will indemnify from any expense or claim of any nature that provides or causes to be provided examination, treatment, or hospital care under this authorization (except to the extent such entity is negligent therein) and conditionally agree to make or cause to be made, by assignment of third-party benefits or otherwise, full and complete payment for such examination, treatment, or hospital care.

**Parent/Legal Guardian Signature: _____ Date: _____**

**Phone Number: _____**

Child's Name: _____ Date of birth: _____

Last tetanus immunization: _____

Allergies: _____

Hospitalization Insurance Co.: _____

Family Medicine or Pediatrician: _____

Type of credit card: _____

Credit card number: _____

Name on credit card: _____

Expiration date: _____