

WWMG must receive permission from a child's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. If the party accompanying your child (baby-sitter, friend, relative, etc.) does not present this information the clinic will attempt to contact you to request permission to treat your child.

**NOTE:**

- A parent/legal guardian must attend a minor's first visit with WWMG
- Minors may not receive immunizations without a parent or legal guardian present.
- In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of "heightened sensitivity" such as STD testing, family planning, mental health, etc.

**PATIENT NAME:** \_\_\_\_\_

**PATIENT DATE OF BIRTH:** \_\_\_\_\_

**TODAY'S DATE:** \_\_\_\_\_

I grant \_\_\_\_\_ (an adult into whose care, the minor has been entrusted) to arrange for and authorize routine and emergency treatment at WWMG. This authorization will be in effect until revoked in writing by me.\*

[ ] Please initial here if you are authorizing the minor to seek and consent to treatment with no adult present.

[ ] Please initial here; We/I acknowledge that we are responsible for all reasonable charges in connection with the care and treatment rendered.

*Please send the insurance card and co-pay (if applicable) to the appointment.*

Parent or legal guardian name: \_\_\_\_\_

In case of emergency, I can be reached at: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_

Other Contact Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relation to patient (documentation may be requested): \_\_\_\_\_

\*additional individuals authorized to obtain care: \_\_\_\_\_