MSU HEALTHTEAM
TREATMENT CONSENT FOR MINOR CHILD OR PATIENT WITH GUARDIANSHIP

I/we, as parents(s) or legal guardian(s) of the child/patient named below, authorize the person(s) listed below to consent to diagnostic evaluation and/or treatment of the minor child or patient when I am not able to accompany my child or this patient to the office.

I/we agree to make every effort to be present whenever my child or this patient needs diagnosis and/or treatment.

I/we further understand and agree that if the physician wants to transfer my child or this patient to a hospital/emergency room, he/she will attempt to contact me for consent. However, if I/we cannot be reached, I/we authorize the person(s) listed below to consent to hospital/emergency room treatment for my child or this patient.

I/we understand and agree that by permitting my child or this patient to appear at the doctor's office, or other medical facility as the doctor may designate, without my presence, I/we may not learn the treatment, procedures, medications and/or diagnostic procedures administered to my child or this patient until after administration.

Finally, I/we understand that I/we may revoke this consent at any time.

This consent is valid for one year from the date I/we have signed this form.

_____ _____
Child's/Patient's Last Name First Name Middle Name Date of Birth

Names of individuals authorized to present my/our child or this patient for care
1. _____

2. _____

3. _____

_____
Parent/Legal Guardian's Signature Date Signed

_____
Parent/Legal Guardian's Signature Date Signed

_____
Witness Date Signed

EMR Internal Other