Consent to Treat Minor Patient Without Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a health care professional without consent from a parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, Stellis Health must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

**Patient Name:** ______________________________________________ **DOB:** _______________

**Effective Date(s):** ________________________________________________________________

**Parent/Legal Guardian Name:** ____________________________________________________

**Phone number(s) where parent/legal guardian can be reached:** ____________________________

Please list those individuals who may give us consent to evaluate and treat your child:

_____________________________________________ ___________________________
Name Relationship to Patient

_____________________________________________ ___________________________
Name Relationship to Patient

**LIMITATIONS**
Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none"): ____________________________________________________________________________________

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**. This consent may only apply to **minors age 16 years and older**.

**AUTHORIZATION**
I (parent/legal guardian name) ______________________________ request and authorize Stellis Health and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I give permission for the person(s) listed above to make medical decisions for my child in my absence. I can be reached at the number above in case of an emergency.

I understand that this consent will last for the dates indicated above or one year if no end date is indicated unless I change my mind and withdraw the consent sooner in writing. If I withdraw consent, it will not affect actions already taken by Stellis Health, PA.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in the language that I can understand.

_____________________________________________ ___________________________
Parent or Legal Guardian Name (please print) Relationship to Patient

_____________________________________________ ___________________________
Parent or Legal Guardian Signature Date