CONSENT TO TREAT MINOR CHILDREN

Please print all information and fill out to the best of your ability.

I, ____, parent or legal guardian of ____, born _________________________, does hereby consent to any medical care and the administration of state required immunizations determined by a physician to be necessary for the welfare of my child while said child is under the care of West River Health Services (Lemmon Clinic) .

I give consent for immunization of HPV-9 series. yes____no____.
I give consent for immunization of Hep A series. yes____no____.
Select one (1) option from below:
Please perform a Well child exam and bill my insurance. ____
Please only perform an athletic physical. Enclosed is $25.00.____

This authorization is effective from ___________ to ___________.

X_______________________________________
Signature of Parent or Legal Guardian

Family address ____
Telephone: Father cell______________ home _____________ work___________
Mother cell _____________ home ________________ work______________
Child's Birthdate ________________
You may be contacted for additional information.

Allergies to drugs or foods _______________________________________
____

Special Medications, Blood Type or Pertinent Information
____
____

Child's Physician ___________________________ Phone _______________
Insurance _________________________________ Policy # _____________
Preferred Hospital ____

This consent form should be taken with the child to the clinic or hospital when the child is taken for treatment.