University Hospitals

NAME OF OFFICE PRACTICE: _____

PARENT/GUARDIAN CONSENT TO TREAT MINOR PATIENTS

ACCOMPANIMENT

I, the Legal Guardian of the minor child(ren) _____ give my
(Print minor child(rens') name)

consent for _____ to be accompanied by the individuals listed
(Print minor child(rens' name)

below to office visits and treatment that requires only general consent. I have already signed the general consent form.

Name	Relationship
_____	_____
_____	_____
_____	_____

NO ACCOMPANIMENT

Please complete this section <u>ONLY</u> if you consent for your minor child to transport himself/herself to office visits and treatment that requires only general consent.

My minor child(ren) _____ has my permission to transport
(Print name of minor child(ren))

himself/herself to receive general treatment that does not require general consent which I

_____ as guardian, have already given.
(Print name of legal guardian)

SIGNATURE

You can contact me by phone:

Home: _____ Cell: _____ Work: _____

I understand that this consent is in place until revoked by me and/or the expiration of one year.

Legal Guardian Signature	Relationship of legal guardian to child(ren)	Date
_____	_____	_____