Brushy Creek Family Physicians

INFORMED CONSENT FOR TREATMENT OF MINOR CHILD

Name of Child_____ Date of Birth_____

Address_____City/Zip_____

Home Phone_____Work Phone _____

Insurance_____ ID_____

[ ] *Unaccompanied Treatment*

I hereby request that treatment be rendered to_____, a minor child for whom I have legal custody or guardianship. I further request that treatment be provided **unaccompanied by a parent or legal guardian.**

Specify name(s) of other individual(s) to accompany child to treatment, if any:

_____

_____

[ ] *Informed Consent* for injections, Vaccines, serums, Toxoids, Immunotherapy:

I understand that, as with the introduction of any agent into the body, there are potential risks and hazards in connection with injections. **These risks include reactions manifested by rashes, hives, respiratory problems, shock, paralysis, brain damage or even death.** I have been given the opportunity to ask questions about the benefits and risk of injections, alternative therapies, risk of non-treatment, procedures to be used and the risks and hazards involved and I believe I have sufficient information to give this informed consent for treatment of my minor child, for whom I am authorized to make this request for treatment.

_____*Parent/Guardian/Custodian Initials*

Emergency Medical Care

In the event of a medical emergency during an unaccompanied visit, I further give my consent for the medical staff of Brushy Creek Family Physicians to **immediately render to my child all medical care deemed necessary in their professional judgment,** including emergency intervention, transport to St. David's Medical Center, and emergency medical, surgical or diagnostic procedures as required.

_____ _____

Printed Name: Parent/Legal Guardian **Signature:** Parent/Legal Guardian

Date:_____(Form expires 1 year from date signed by Guardian)

Witness:_____Date_____