WMed Health Parental Authorization for Treatment of a Minor

We or I __________________________, the parent(s), guardian(s), or power of attorney of ____________________________ give WMed Health and its employees the right to treat my son or daughter or legal ward at their scheduled office visit, or diagnostic testing. Treatment includes evaluation and consent to any procedure completed during an office visit. This includes and is not limited to x-rays, breathing treatment, and laboratory tests.

This treatment is to include medications (circle one):  Yes  No  This treatment is to include immunizations (circle one):  Yes  No

STATEMENT BY PARENT OR GUARDIAN AUTHORIZING AN ADULT OTHER THAN THEMSELVES TO OBTAIN TREATMENT FOR MINOR CHILD

I hereby authorize the ADULTS NAMED BELOW* (must be 18 years of age or older) to accompany my minor to his/her scheduled appointment and schedule ongoing appointments.

Patient Name: ______________________________________________________

1. ________________________________________________________________
   Authorized Person: ___________________________ Phone Number: ___________________________ Relationship to Patient: ___________________________

2. ________________________________________________________________
   Authorized Person: ___________________________ Phone Number: ___________________________ Relationship to Patient: ___________________________

3. ________________________________________________________________
   Authorized Person: ___________________________ Phone Number: ___________________________ Relationship to Patient: ___________________________

WMed Health should be made aware of any special custodial relationships, if applicable, please explain in the space below. Documentation will be required.
(Example: parents are divorced but only one parent has guardianship, etc.)
________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

IF YOUR CHILD IS OVER 16 YEARS OF AGE:

Do you authorize the child listed above to attend WMed Health appointments by himself/herself (circle one)?  Yes  No

I understand this authorization will expire in one year from date signed.

Signature: ____________________________________________ Date: ___________ Time: ___________

Relationship (circle one):  Parent  Guardian  Power of Attorney

Interpreter’s Statement: I have interpreted the text on this form to the parent(s), guardian(s), or power of attorney.

Interpreter’s Signature: ____________________________________________ Date: ___________ Time: ___________

Emergency Contact: ____________________________________________