Consent for Treatment of a Minor

2022

Dear Parent or Legal Guardian,

Thank you for choosing Westminster Medical Clinic to care for your child(ren)'s health care needs! Our mission is to provide quality, safe care for you and your child(ren). The state of healthcare today places many legal and ethical considerations on us as healthcare providers when treating minors under age 18.

To help us continue to provide excellent care for your child(ren), we ask you to complete the enclosed <u>ONE-TIME</u> consent form giving us written authorization to care for your child(ren) through age 18. Please return the consent form to us by:

- **Bringing the completed consent form to you or your child(ren)'s next visit**
  OR
- **Mailing it using the enclosed return envelope**

Your written consent is particularly important in cases when a parent/legal guardian is not present. Examples include when older teens might come alone to an appointment because they are able to drive or younger children may be accompanied by a grandparent or other family member. **If you have any questions or concerns about this consent form, please do not hesitate to contact us at (303) 428-7449.**

We value your partnership with us and appreciate your time to complete the consent form. Thank you!

Sincerely,

Westminster Medical Clinic

Consent for Treatment of a Minor

PLEASE LIST THE NAMES OF ANY CHILDREN/MINORS WHO ARE PATIENTS AT WESTMINSTER MEDICAL CLINIC (WMC).

PATIENT NAME (please print)	**DATE OF BIRTH**	**TODAY'S DATE**
PATIENT NAME (please print)	**DATE OF BIRTH**	
PATIENT NAME (please print)	**DATE OF BIRTH**	

I authorize WMC to treat my child(ren) listed above and provide the following services should his/her condition require it per the judgment of a WMC provider, including but not limited to:

- Routine medical care such as diagnosis and treatment of illness/injury or prescription medications
- Diagnostic testing (e.g. x-ray, lab testing, etc.)
- Well child visits, including recommended immunizations
- Emergency care, including referral to hospital or emergency room if needed

As long as the medical care considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment. I agree to hold WMC free and harmless from any claims, suits for damages or complications that may result from such treatment.

I authorize WMC to treat my child(ren) when he/she/they are not accompanied by either parents or legal guardians listed below, and it may not be feasible or practical to contact them. When appropriate, WMC will make every reasonable attempt to contact the below listed parents or legal guardians. It is understood that this authorization is given in advance of any such medical care, but is given to provide authority on the part of WMC providers in the exercise of his or her best judgment.

PARENT/LEGAL GUARDIAN NAME (PRINTED)	PRIMARY PHONE
PARENT/LEGAL GUARDIAN NAME (PRINTED)	PRIMARY PHONE

PARENT/LEGAL GUARDIAN: I acknowledge that I am the above listed child(ren)'s parent/legal guardian. I have read and fully understand this consent form, and I consent to allow Westminster Medical Clinic to treat my child(ren) listed above. I understand this authorization may be changed at any time by providing a new authorization in writing but is otherwise valid until the minor reaches age 18.

PARENT/LEGAL GUARDIAN SIGNATURE	**DATE**