CONSENT TO TREATMENT OF A MINOR

MINORS AGE 15 AND UNDER:

Written consent from parent or legal guardian;
An adult must accompany the patient during the visit.

A Consent Form must be signed for each visit.

I, ______________________________, authorize Keller Family Medical Center
(Parent/Legal Guardian Name)
to treat ______________________, my minor child on ____________________.
(Patient Name) (Date)

Symptoms patient is experiencing:

________________________________________________________

________________________________________________________

Phone number provider can contact you at if necessary ______________________________

Signed ______________________________ Date ______________________________

MINORS AGE 16 AND 17:

Written consent from the parent or legal guardian

I, ______________________________, authorize Keller Family Medical Center
(Parent/Legal Guardian Name)
to treat ______________________, my minor child on ____________________.
(Patient Name) (Date)

Phone number provider can contact you at if necessary ______________________________

Signed ______________________________ Date ______________________________

All minors must be accompanied by their parent of legal guardian for
immunizations, invasive procedures, lab draws or injections.