Patient name: ______________________
Medical record #: ____________________
Date of birth: ____ / ____ / _______

Consent for Treatment of Minor Patient

Name of parent or legal guardian: ____

Address: ____

Primary contact number: ____

As the parent or legal guardian for the patient, I will allow the health care team at Fairview Health Services to give the following treatments to my child (under age 18).

☐ Well child check-up

☐ For a minor illness (cough, sore throat, ear ache)

☐ Shots (to immunize against disease)

☐ Strep test

☐ For other minor conditions (describe): ____

☐ Prescribed treatment (describe): ____

I understand that:

- This consent applies only to the treatments listed above.
- This consent applies only when I am not present with my child at the hospital or clinic to give consent to treatment.
- If I am with my child at the hospital or clinic, I will decide whether to give consent to the suggested treatment.
- Minnesota law allows minors to consent to treatment for pregnancy, venereal disease, alcohol or drug abuse and hepatitis B vaccines without the consent of a parent or legal guardian.
- This consent for treatment is **valid for one year** unless a shorter timeframe is listed below:

  Start Date: __________ **End Date:** _________

- I may revoke (take back) this consent at any time by telling the hospital or clinic in writing. Any such action will take effect only when the hospital or clinic receives my written notice.

____ __________________ __________________
Signature of parent/legal guardian **Date** **Time**

____ ____
Print name of parent/legal guardian **Relationship to patient**