



Pickerington Primary Care

Consent to Examine a Minor Without Parental/Guardian Presence

Complete Section A or B as appropriate, or both.

SECTION A

As the parent(s)/legal guardian of _____, I hereby give my
(Patient name / Printed, including date of birth)
consent to the physicians of _____ to examine and treat the above
(Location Name)
named patient without my presence. In case of emergency, the above named medical facility has my
permission to transport _____ to _____ or nearest
(Child's Name) *(Preferred Hospital)*
hospital in my absence.

SECTION B

As the parent(s)/legal guardian of _____ I hereby grant the following
(Patient Name / Printed, including D.O.B.)
individual(s) the authority to consent to examine and treat the above named patient in my absence:

_____	_____
<i>(Name)</i>	<i>(Relationship)</i>
_____	_____
<i>(Name)</i>	<i>(Relationship)</i>
_____	_____
<i>(Name)</i>	<i>(Relationship)</i>
_____	_____
<i>(Name)</i>	<i>(Relationship)</i>

This consent to examine & treat shall be in effect throughout the duration of the patient/physician relationship unless otherwise revoked or replaced by the parent/guardian. This includes any necessary medical testing, admissions, examination, blood and urine samples, administering of antibiotics or medications, immunizations, IVs, x-rays or any procedures deemed necessary for the health and well-being of my minor child. This form will become a part of the patient's medical record.

_____	_____
<i>(Printed Name of Parent/Guardian)</i>	<i>(Signature/Date)</i>
Phone Numbers & Hours of Availability:	
Home: _____	
Work: _____	
Cell: _____	

Witnessed by: _____ Date: _____