Patient Name:_____ Date of Birth:_____

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: _____