Kids Creek Children's Clinic

Fax: 231-935-0562

Consent for Treatment

Date of Visit:___________________

☐ **Consent for patients being brought to the office by someone other than the parent or legal guardian.**

I, the parent or legal guardian of ___________________________________hereby

authorize ____
(name and relationship to patient)
to bring my child to the office today for evaluation and treatment. I have provided the above named with the necessary health history for my child.

Reason for visit:__________________________ Child's drug allergies:_________________

☐ **Consent for a patient who is 16 years of age or older and coming to the office alone:**

I, the parent or legal guardian of ___________________________________hereby
authorize Kids Creek Children's Clinic to evaluate and treat him/her without my being present.

Reason for visit:__________________________ Child's drug allergies:_________________

Parent/Legal Guardian Signature: Date

I will be available at the following phone number(s) should the office staff need to contact me:

1. (   ) ___________________________

2. (   ) ___________________________