

DOC TYPE



10044

**VANCOUVER CLINIC  
Consent for Treatment of Minor Children**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**1. ACCOMPANIED MINOR:**

I, \_\_\_\_\_ authorize Vancouver Clinic to treat my minor child for routine and emergency medical treatment when deemed necessary by qualified medical personnel when accompanied by the following (list names):

\_\_\_\_\_

**2. UNACCOMPANIED MINOR:**

I, \_\_\_\_\_ authorize Vancouver Clinic to treat my minor child, when unaccompanied, for routine, and emergency medical treatment.

**EXCLUSIONS:** Minor medical procedures (i.e. wart, mole, or toenail removal, etc.).

**If your child will be receiving immunizations during the visit** – in addition to this form, you will also need to fill out the Child and Teen Immunization Screening Form.

- **One screening form is required for each immunization given, every time immunizations are given.**
- **I UNDERSTAND** that both the **Unaccompanied Minor Authorization**, and the **Child and Teen Immunization Screening Form(s)** are **required** in order to administer immunizations to an unaccompanied minor.

**This authorization will automatically expire in one year from date signed**, unless you wish it to expire sooner. If so, enter date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.

- **I UNDERSTAND** I must have an existing, valid phone number on file in my minor child's chart for verification purposes.
- **I UNDERSTAND** that I can select either or both of the options listed above.
- **I UNDERSTAND** that I may revoke this request in writing. If revoked, it would not affect any actions already taken by Vancouver Clinic based upon this authorization.

\_\_\_\_\_  
Printed name of parent/legal guardian

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date

*For internal use only:*

_____ Verified with parent/legal guardian in person or on the phone	_____ Staff Initials	_____ Date
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