Patient Name: __________________________
Date of Birth: ___________________________

CONSENT FOR TREATMENT OF MINOR CHILDREN

1. ACCOMPANIED MINOR:

I, ____________________ authorize The 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 The 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 visit, every time immunizations are
given.
• I UNDERSTAND that both the Unaccompanied Minor Authorization, and the Child and Teen
Immunization Screening Form 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 The Vancouver Clinic based upon this authorization.

Printed name of parent/legal guardian

_______________________________________
Signature of parent/legal guardian Date

For internal use only:

_________ Staff Initials
_________ Date

______ Verified with parent/legal
guardian in person or on the phone