Van Wert Health

Consent for Minor Treatment

Designation of Another Person to Consent for Medical Care for Minor Patient

Patient Name (Last, First, MI)	Date of Birth

I, _____, give permission to the staff of Van Wert Health to treat me minor child in the event that I am unable to accompany said patient to his or her appointment(s) or to the hospital.

Therefore, I give permission to _____ (person, who is 18 years of age or older, to accompany the minor) as follows:

Please mark one:

☐ I give permission for this person to seek medical treatment (including any type of procedure, surgery, or spinal tap) and provide consent for such treatment if attempts to contact me are unsuccessful.

☐ I give permission for this person to seek medical treatment (including any type of procedure, surgery, or spinal tap) and provide consent for such treatment without having to contact me.

This includes bringing the minor to Van Wert Health, providing a history of present illness, disclosing protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider.

This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian.

I agree to be financially responsible for all copays, coinsurance, and any charges not paid by insurance.

Please mark one:

☐ This form will remain in effect until revoked in writing.

☐ This form is VALID ONLY during the following dates:

Effective Date: _____

Expiration Date: _____

_____ _____

Signature of Parent/Legal Guardian | Date/Time

_____ _____

Signature of Witness | Date/Time

Parent or Legal Guardian Information

Name	Relationship to Patient
Address	
Cell Phone	**Other**

Form revised August 2021

Van Wert Health

Medical Information for Medical Care for Minor Patient

Patient Name (Last, First, MI)	Date of Birth	Social Security Number

Health Insurance Information

Health Insurance Company Name		Phone Number
Policy Number	**Group Number**	**Group Name/Employer**
Member Name		**Member ID Number**

Patient's Medical Information

Allergies
Allergies to Medications
Medication(s) Child is Taking

Other Information to be Attached to this Document	
☐ Immunization Record	☐ Photocopy of Insurance Card (Front/Back)
☐ Photo ID of Parent Giving Permission	☐ Other: _____

Provider Information

Primary Care Provider	Phone Number
Surgeon/Orthopedist	**Phone Number**
Preferred Pharmacy	**Location/Address**

Parent or Legal Guardian Information

Primary Care Provider		Relationship to Patient
Address		
Cell Phone		**Other**

Form Completed By

Printed Name	Signature	Date

Form revised August 2021