UW Medicine
UW NEIGHBORHOOD CLINICS

Permission to Treat a Minor without a Parent/Guardian Present

UW Neighborhood Clinics must receive permission from a child's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening. This form gives us legal permission to treat your child in case you cannot accompany him/her to the clinic for treatment. If the party accompanying your child (baby-sitter, friend, relative, etc.) does not present this information the clinic will attempt to contact you to request permission to treat your child.

Note:

- *A parent/legal guardian must attend a minor's first visit at a UW Neighborhood Clinic.*
- *Minors may not receive immunizations without a parent or legal guardian present.*
- *A new "Permission to Treat a Minor without a Parent/Guardian Present" form is required for each visit that a minor will be seen without his/her parent/legal guardian.*
- *In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being seen for concerns of "heightened sensitivity" such as STD testing, family planning, mental health, et cetera.*

Patient's Name: _____

Patient's Date of Birth: _____ Today's Date: _____

I grant _____ (an adult into whose care, the minor has been entrusted) to arrange for and authorize routine and emergency treatment at UW Neighborhood Clinics on _____ _____(date).

_____ Please initial here if you are authorizing the minor to seek and consent to treatment with no adult present.
We/I acknowledge that we are responsible for all reasonable charges in connection with the care and treatment rendered.

Please send the insurance card and co-pay (if applicable) to the appointment.
If the visit will not be covered by insurance, a deposit of $140 is needed at the time of the visit.

Name of Health Insurance Carrier:	
Group Number:	
Subscriber ID:	

In case of emergency, I can be reached at:

Address:	
Home Phone Number:	
Work Phone Number:	
Other Contact Phone Number:	

Signature: _____ Date: _____

Relation to patient (documentation may be requested): _____