

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.
This general consent form does not permit minors to receive procedural treatments or immunizations; special consent is required for this type of care/treatment.
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.

OR

I am authorizing the minor to seek and consent to treatment with no adult present.

This consent is valid only for (specific date or visit reason)

OR

This consent is valid through (end date, maximum 1 year)

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 self-pay deposit is needed at the time of the visit.

Table with 2 columns: Label (Name of Health Insurance Carrier, Group Number, Subscriber ID) and Input field.

In case of emergency, I can be reached at:

Table with 2 columns: Label (Address, Home Phone Number, Work Phone Number, Other Contact Phone Number) and Input field.

Signature: Date:

Relation to patient (documentation may be requested):