WESTERN WISCONSIN HEALTH

# Consent to Treat – Minor/Other

Name of Patient: _____ DOB: _____

Parent/Guardian or Legal Representative Name: _____

Address: _____ City: _____ ZIP: _____

Phone: _____

If the patient (either minor child or individual with a guardian/legal representative) noted above seeks treatment at Western Wisconsin Health, I the parent/guardian or legal representative, grant authorization to Western Wisconsin Health staff to provide ambulatory medical care that is in the patient's best interest. Examples include, but are not limited to immunizations, medical exams and treatment, physicals, physical therapy, etc.

In addition, I recognize that in my absence, the following individuals/care facilities might accompany the patient and I authorize them to provide verbal/written consent.

This authorization is valid from _____ to _____ **OR** ☐ has no end date.

Name of Individual(s) authorized to consent for care:

_____
Name/Facility Relationship

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

_____ _____
**Parent/Guardian or Legal Representative Signature** **Date / Time**

Please Place a Current Admission Sticker Here When Available

Patient Name: _____

Date of Birth: _____Med Rec #: _____