



Permission to Treat a Minor Without a Parent or Guardian Present

Madison Regional Health System must receive permission from a minor's parent or legal guardian before providing treatments for an injury or illness that is non-life threatening (consent to treat is generally implied in emergency situations). This form gives us legal permission to treat your child(ren) in case you cannot accompany him/her to Madison Regional Health System for treatment.

PLEASE NOTE:

A parent or legal guardian must provide this form directly to the admitting office, at Madison Regional Health System. In certain circumstances, in accordance with State and Federal laws, parent/guardian permission may not be needed for adolescents being treated for concerns deemed as "heightened sensitivity," including STD testing.

***This form must be completed in its entirety to be valid.*

Patient's Name: _____
Date of Birth: _____ Allergies to drugs or foods _____
Medications _____ Primary Care Provider _____

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AUTHORIZATION

I, _____, the natural parent/legal guardian, of child(ren) named above, grant :
_____, (relationship); _____

(an adult into whose care, the minor has been entrusted), to arrange for and authorize treatment at Madison Regional Health System.

Valid from _____ (date) to _____ (date)
-OR-

Valid for the duration of adolescence, unless revoked in writing

I acknowledge that as the parent or legal guardian that I am responsible for all reasonable charges in connection with the care and treatment rendered for my minor child(ren). I understand that the adult authorized must bring the insurance card and a co-payment (if applicable) to the appointment.

In case of an emergency, I can be reached at:

Name: _____

Address: _____

Phone Numbers: Home: _____ Work: _____ Other: _____

Signature of Parent/Legal Guardian: _____

Date: _____

MRHS Witness: _____