Royal
KIDS
Pediatric Clinic

CONSENT TO TREAT MINOR

I, _____ authorize ROYALKIDS CLINIC to provide medical care for _____ (Patient Name) born on _____ (Date of Birth) including immunizations, physical examinations, and testing/treatment for the purpose of medical diagnosis and treatment, which is deemed advisable by and is to be rendered by the providers and staff of ROYALKIDS CLINIC.

This authorization is effective as of _____ (Date)

Parent/Legal Representative (Print Name):_____
Parent/Legal Representative Signature: _____
Date: _____Time:_____AM/PM
Witness: _____ Date:_____Time: _____AM/PM

Note: ROYALKIDS CLINIC will be unable to treat any minor (under the age of 18) without a parent or legal guardian present. Minors 12 years and older may consent to medical diagnosis, or treatment of the following: infectious or communicable diseases which must be reported to the local health officer; STDs, rape or HIV testing, mental health therapy or drug or alcohol related problems. Minors of any age may consent to medical diagnosis and/or treatment of the following: contraception, pregnancy, and diagnosis or treatment of sexual assault.