Clinic For Special Children
TREATING THE WHOLE CHILD

# Consent to Treat a Minor

*Please note: Both parents/guardians must sign this consent form prior to intake/ rendering of services. If there are not two legal guardians, court order/ documentation of such must be provided to Clinic for Special Children prior to scheduling.*

Patient Name: _____

Date of Birth: _____

Parent/ Guardian Name #1: _____

Parent/ Guardian Name #2: _____

I/ We understand that signature of this document hereby consents to any medical care determined by a physician to be necessary for the welfare of my child by authorized members of the Clinic for Special Children staff, as may in their professional judgment be necessary.

As the parent/ legal guardian(s) of the child listed above, I/ We certify and declare legal guardianship of the child listed herein and that there are no court orders preventing or limiting my rights to grant this authorization.

The authority granted under this Child Medical Consent form may be terminated through a written notification addressed by the caregiver(s) named above and to the child/ children's medical providers, stating that I wish to revoke it.

**I have read this form and certify that I understand its contents.**

Parent/ Guardian Name #1: _____

Parent/ Guardian #1 Signature: _____

Relationship to the Patient: _____Date: _____

Parent/ Guardian Name #2: _____

Parent/ Guardian #2 Signature: _____

Relationship to the Patient: _____Date: _____