McCRIMMON PRIMARY CARE *plus*

MINOR CONSENT FOR TREATMENT FORM

In order for us to provide medical treatment to a minor **without a parent or legal guardian present**, please complete this consent form **and return it along with a copy of the parent's or guardian's driver's license** to McCrimmon Primary Care Plus.

Parent/Legal Guardian Information

Name (Last, Middle, First): _____ Date of Birth (MM/DD/YYYY): _____

Minor Patient Information

Name (Last, Middle, First): _____ Date of Birth (MM/DD/YYYY): _____

I authorize **McCrimmon Primary Care Plus** to provide medical care to my son/daughter listed above, including but not limited to: diagnostic examinations (including laboratory testing and imaging), treatment procedures, and prescribing medications as deemed appropriate by their provider.

*Date of Service (MM/DD/YYYY): _____

I understand that if further invasive diagnostic or surgical procedures are needed, McCrimmon Primary Care Plus will attempt to contact me at the number(s) provided below prior to proceeding with care.

Emergency Contact Information

Primary Phone: _____ Alternative Phone: _____ Address: _____

Parent/Legal Guardian Signature

By signing this form, I confirm that I have read and agree to this consent.

Driver License State: _____ Driver License Number: _____

Signature: _____ Date Signed: _____