WEST RIVER HEALTH SERVICES®

Consent to Treat Minor Children

Please print all information and fill out to the best of your ability.

I, _____, Parent or Legal Guardian of:

_____, born _____, do hereby consent to any medical care and the administration of state required immunizations determined by a physician to be necessary for the welfare of my child while said child is under the care of West River Health Services, _____(Clinic).

I give consent for immunization of HPV-9 series: Yes _____ No _____.

I give consent for immunization of Hep A series: Yes _____ No _____.

Select one option from below:

Please perform a Well-Child Exam and submit bill to my insurance. _____

Please only perform an Athletic Physical. Enclosed is $45.00. _____

This authorization is effective from _____ to _____.

X _____ (Signature of Parent or Legal Guardian).

Family Address: _____

Telephone: Father Cell: _____ Home _____ Work _____

Mother Cell: _____ Home _____ Work _____

Child's Birthdate: _____ (You may be contacted for additional information).

Allergies to drugs or food: _____

_____

Special Medications, Blood Type, or Pertinent Information: _____

_____

Childs Physician: _____ Phone: _____

Insurance: _____ Policy Number: _____

Preferred Hospital: _____

This consent form should be taken with the child to the clinic or hospital when child is taken for treatment.