CONSENT TO TREAT A MINOR

(866)707-OMNI (6664) www.OmniFamilyHealth.org

Omni Family Health

In the event I, (name of parent/guardian) _____, am unable to accompany my child (child's name and DOB) _____ to an appointment at an Omni Family Health clinic. I give permission for the following people to bring him/her (Person must be over 18 years old, with a valid photo ID, and must have a copy of parental driver's license or ID if this form is returned by someone other than the parent):

Name	DOB	Relationship to Child

Please select all that apply:

□ I give permission for this person to seek treatment (including any type of medication or diagnostic test needed) without having to contact me.

□ I give permission for this person to consent for minor procedures or diagnostic tests, etc. without having to contact me.

□ I give permission for this person to consent to vaccines without having to contact me.

□ I give permission for this person to consent to seek dental evaluation and treatment without having to contact me.

□ I give permission for this person to bring my child in for any behavioral health services

Expiration (check ONE):

□ There is no expiration to this designation.

□ This designation is valid only during the following time frame:
Effective From: _____ Until: _____

□ Is there anyone who is NOT allowed to consent for medical or Dental visits/treatment for this child? If so, please provide legal documentation to have on file and name(s) of person(s) _____

_____

Reminder: Please have person bringing your child in bring proof of their identification (i.e. valid driver's license/passport) at the time of the visit.

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____ _____
Home Phone Cell Phone Work Phone

_____ _____
Omni Family Health Staff's Signature Date

Reviewed Details and Date: