



CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN

I, _____, the natural parent/legal guardian of: _____, authorize and consent to have the following medical care delivered in my absence at the Family Wellness Center, PC.

- Allergy injections
- Emergent care (sutures, casts, etc.)
- F/U care e.g.: my son or daughter may be seen without me for routine care and follow up appointments.
- School and/or sports
- Suture removal
- Medication administration
- Immunizations
- X-rays
- Laboratory studies

I hereby agree to accept responsibility for any financial indebtedness incurred, at the physicians' office. I agree to pay all necessary services at the current rate.

Childs Name: _____(please print)

Parent /Guardian _____(signature)

Witness _____(signature)

Date effective: _____ Date expired: _____



CONSENT FOR EMERGENCY TREATMENT AND CARE FOR MY CHILD IN MY ABSENCE

To: Family Wellness Center, PC
1000 SE Tech Center Dr.
Suite #120
Vancouver, WA 98683
(360) 260-2773

I hereby give my consent for my child _____,
DOB: _____, to be treated in our absence when accompanied by:
_____, who will be caring for our child
during our absence from (date) _____ to _____.

All routine, emergency medical care and treatment may be rendered to
preserve the health of my child by authorized members of the clinic staff, as
may, in their professional judgment, be necessary.

I acknowledge that I am responsible for all reasonable charges in connection
with the care and treatment rendered during this period.

Signed: _____ Date: _____

Witness: _____ Date: _____

Patient Address: _____
_____ Telephone # _____

Medicine my child is taking: _____

My child's allergies _____ Last tetanus booster? _____

In case of emergency, I can be reached at: _____