Bluegrass Med Care
Primary and Preventative Medicine

TREATMENT OF A MINOR

To All Parents:

We are required to obtain a parent's consent treat a child (unless a matter of life or death). It is requested that you complete the information below so that if your child presents to BLUEGRASS MED CARE either alone or in the company of an adult (not a legal guardian) for an office visit, this will allow the BLUEGRASS MED CARE medical staff to assess and treat the child as necessary. This consent is valid for 6 months. You will be required to sign another consent if the previous consent for has expired.

Minor's Name: _____ DOB: _____ SEX: M OR F

Mother's Name: _____ DOB: _____

Mother's Home Address: _____

Home: _____ Cell: _____ Work: _____

Father's Name: _____ DOB: _____

Father's Home Address: _____

Home: _____ Cell: _____ Work: _____

Additional Contact: _____

Relation to Minor: _____ Phone: _____

Allergies (Minor Child): _____

Consent Statement Authorizing Treatment:

I hereby attest that I am a legal guardian of _____ and hereby give my consent you between the hours of _____ and _____ to discuss the office visit of the above-named minor.

_____ _____
PARENT/GUARDIAN DATE

_____ _____
WITNESS SIGNATURE DATE