

CONSENT TO TREAT A MINOR

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



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: