Carolinas HealthCare System

Parental Consent to Treat for Minors

Signing this form gives Teen Health Connection permission to treat the patient indicated for services/care specified below. This consent form will be valid for one (1) year, or until our practice is notified otherwise.

As the parent or legal guardian, I _____ (your name), give permission for _____ (print patient's name clearly) Date of Birth _____

to be seen at Teen Health Connection according to the guidelines listed below:

- ○ May visit the physicians' office alone
- ○ May visit the physicians' office with a responsible adult

Please print below the name of the responsible adult that may bring your child for their appointment.

NAME_____ Relationship_____

NAME_____ Relationship_____

NAME_____ Relationship_____

As the parent/legal guardian, I give permission for the following:

- ○ Immunization
- ○ Sick visits
- ○ Other_____

Please Note Parent/legal guardian **Must** be present for annual physicals, new patient (non STI and birth control) and psychotropic medication appointments.

If additional treatment is needed, I am to be contacted to give verbal consent.

I can be reached at: _____(Phone)

Parent/Legal Guardian Signature_____ Date_____