

WASSAJA MEMORIAL HEALTH CENTER

Fax: 480-837-1270

CONSENT TO TREAT

Date of Visit: _____

Consent from Parents or Guardians for Authorized Person:

As the parent/guardian of _____, I am granting permission for the
(Minor's Name)
below listed person(s) to bring my minor/child in for treatment and/or care.

PLEASE SELECT ONE OF THE FOLLOWING CHOICES:

I am granting full permissions, meaning the below listed person(s) will be allowed to agree to treatment/vaccines, and know all health history pertaining to my minor/child. _____ **Initials**

I am granting permissions, meaning the below listed person(s) is only allowed to bring my minor/child in, and will have access to all health history, but not allowed to agree to treatments without my direct consent. _____ **Initials**

I am granting limited permissions, meaning the below listed person(s) is allowed to bring my minor/child into the office, but is not allowed access to any medical information or treatment of my minor/child. I will be informed of the visit results, and I will be notified prior to any treatment for my minor/child.
_____ **Initials**

Please list person(s) here

Relationship

Consent to Leave voicemail

I am granting permission to Wassaja Memorial Health Center to leave phone messages regarding my minor/child's medical health to the number(s) provided on the registration form. _____ **Initials**

Parent/Guardian Signature

Date

Witness Signature

Date