20601 West Paoli Lane
Weimar, CA 95736

Policy # IF - 2
Effective date: 9-23-15
Date Revised: 9-18-16

Consent to Treat Minors

I, the undersigned parent or legal guardian of a minor, do hereby request and authorize the Stallant Health Physician and/or mid level provider, and other health care providers or their designees, to perform medical examination, testing, x-ray, anesthetics, treatment, and care as may be deemed necessary and available for my child during his/her office visit or outpatient procedure. I understand that by signing this consent, I am authorizing Stallant Health to treat my child for as long as I seek care for my child from this facility, or until I withdraw my consent in writing.

You have the right to discuss your child's treatment plan with your physician, including the purpose, potential risks, and benefits of any test ordered. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents, including consent to be treated by Stallant Health.

_____ _____
Print Minor Patient's Name *Date*

_____ _____
Print Name of Parent or Legal Guardian *Date*

_____ _____
Signature of Parent or Legal Guardian *Date*

Permission for Alternate Person to accompany a Minor

It is best for the parent or guardian to accompany their child to each office visit; however, we realize that at times this is not practical, due to work schedules, etc. Therefore, if you desire an alternate person to be able to accompany your child to any of their clinic visits, we need you to complete the following form. The alternate person must be 18 years old or older.

I will not always be able to accompany my child to Stallant Health, therefore, I give permission to the following alternate person to accompany my child(ren) to the Stallant Health clinic.

_____
Print name of person allowed to accompany my minor(s) as listed below to Stallant Health

Name(s) of my children who may be accompanied by above named person (please print legibly).

_____ _____

_____ _____

I further give permission for the above named person to seek and approve treatment for my above mentioned children (including medical exam, procedures, medications, immunizations, diagnostic testing, mental health care, etc.) and provide consent for such treatment.

_____ _____
Print Name of Parent or Legal Guardian *Date*

_____ _____
Signature of Parent or Legal Guardian *Date*

Revised: 2/29/16