Winneshiek MEDICAL CENTER | Physician services by MAYO CLINIC HEALTH SYSTEM

Consent for the Treatment of a Minor

Minor's Name: _____

Date of Birth: _____

Account Number: _____

Phone Number: _____

I hereby authorize the care of the above named minor, which in the opinion of the attending health care provider, requires diagnostic and/or medical treatment.*
This release form is for the sole purpose of authorizing medical treatment in the absence of a parent or guardian and **expires on December 31st of this year.**

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Address: _____

Parent/Guardian's Phone: _____
(Indicate if Home, Work or Cell)

In my absence, the following people have my permission to give medical consent:

Name: _____
Relation to minor: _____
Phone number: _____

Name: _____
Relation to minor: _____
Phone number: _____

Name: _____
Relation to minor: _____
Phone number: _____

Immunizations and allergy injections require a separate informed consent by a parent/guardian. A separate consent is needed for additional testing or invasive procedures. Parent/guardian(s) are responsible to follow-up with their minor's provider regarding the results of the medical examination.