Center for Family Medicine

1115 E. 20th Street
Sioux Falls, SD 57105
(605) 339-1783
centerforfamilymed.org

Parental/Guardian Consent for Treatment of Minor
(Children under the age of 18 years)

I, _____ , authorize the following individuals (caregivers):
name of parent/guardian

_____

_____

_____

to accompany and authorize medical treatment for (name of child(ren) and date of birth):

_____
Name of child — Date of Birth

_____
Name of child — Date of Birth

_____
Name of child — Date of Birth

I understand that I will be responsible for all charges incurred while at the clinic to include laboratory, radiology and physician fees. I further give permission to bill my insurance company for such services. My signature below means that I have read, understand and give my consent as stipulated above.

_____
Parent/Guardian Signature — Date

I, _____ , authorize _____
name of parent/guardian — name of minor child

to receive medical care without an accompanying adult for the following services at Center for Family Medicine (check all that apply):

- ☐ Continuous Treatment
- ☐ New Care

I understand that I will be responsible for all charges incurred while at the clinic to include laboratory, radiology and physician fees. I further give permission to bill my insurance company for such services. My signature below means that I have read, understand and give my consent as stipulated above.

_____
Parent/Guardian Signature — Date