Traverse Health Clinic and Coalition
D.B.A. Traverse Health Clinic

Consent for Treatment on Behalf of a Minor

Name of Minor Patient: _____

Date of Birth: ____/____/____

I am authorized to consent on behalf of the above named minor as I am the minor's parent
[circle if yes]
or _____.
[State relationship to minor that grants authority]

I _____[*Print the name of parent or legally authorized person*] hereby and voluntarily consent to authorize health care providers to provide health care services to the above named minor at the Traverse Health Clinic (the Clinic). The health care services may include, without limitation, routine physical and behavioral health assessment; diagnostic and monitoring tests and procedures; examinations and medical and/or dental treatment; routine laboratory procedures and tests; x-rays and other imaging studies; administration of medications; as well as procedures and treatment prescribed by the Clinic's health care providers. The health care services also may include counseling necessary to receive appropriate services.

I understand that I will be asked to sign a separate informed consent for vaccines to be administered to my child and that I will receive a "Vaccine Information Statement (VIS) prior to my child receiving each vaccine. I understand that I may be required to sign a separate parental consent form in order for my child to receive family planning services. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given knowing this.

I understand that this consent is valid and remains in effect as long as my child is a patient of the Clinic, until I withdraw my consent, until the Clinic changes its services and asks me to complete a new consent form, or until my child turns 18 and must consent for services on his or her own behalf.

Delegation of Authority to Consent for Minor
(complete this section if delegating authority)

I hereby delegate authority to consent to treatment for the above named minor to:

[Print Name]: _____

for the period of ____/____/____ through ____/____/____ (This period cannot be greater than six months)

The delegated authority may not provide consent for the following identified services:

_____

_____

Consent Provisions

My signature on this form indicates that:

1. I certify that I have read and fully understand the foregoing consent and that the facts indicated above are true.
2. I realize that although every effort will be made to keep all risks and side effects to a minimum, risks, side effects, and complications can be unpredictable both in nature and severity.
3. I understand that I may be asked to sign a separate informed consent form for certain treatments(s) that require such.
4. I hereby voluntarily give my consent for my child's treatment at the Clinic.

_____

[Print Name of Parent/Legal Representative]

_____ _____

[Signature of Parent/Legal Representative] [Date/Time]

_____

[Print Name of Witness]

_____ _____

[Signature of Witness] [Date/Time]

Interpreter/Translator to complete when applicable:

I have accurately and completely read/translated the foregoing document to:

_____

[Insert the Parent/Legal Representative's Name]

in _____, the Parent/Legal Representative's primary language. She/he understood all of the terms and conditions and acknowledged his/her agreement and consent thereto by signing the document in my presence.

_____

Print Name of Interpreter/Translator Signature of Interpreter/Translator Date/Time