



CONSENT TO TREAT A MINOR
(if applicable)

Father's Name: _____ DOB ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (OK to call Y/N)

Mother's Name: _____ DOB ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (OK to call Y/N)

Guardian's Name: _____ DOB ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ (OK to call Y/N)

Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please circle all that apply to minor and family:

Divorce, Legal Separation, Custody/Guardianship Restraining Orders, Current Litigation Issues, Probation

Any issues concerning Divorce, Custody, Guardianship, Probation and/or Restraining Orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records

I, (print name) _____, am the mother/father/legal guardian (circle one) of

_____ and I authorize **Urgent Medicare** to provide medical treatment with **Urgent Medicare**. _____ (initial here)

I, (print name) _____, authorize the Emergency Contacts to accompany my child, and I authorize **Urgent Medicare** to provide medical treatment to said minor. I also agree to be legally responsible for any charges said minor may incur during the treatment with **Urgent Medicare**. _____ (initial here)

Signature: _____ Date: _____