# TREATMENT OF A MINOR

OP 4 – 009.000.01

**Regarding Treatment of a Child:** Treatment of minors (age 17 and under) requires a team effort by the medical provider(s) and the child's parent, guardian, or caregiver. The parent or guardian's responsibility includes supporting the medical directives given by the provider. The provider's role includes ensuring that the parent, guardian, or caregiver is aware of and concurs with the treatment of their child or charges received.

**Treating Minors without Parents/Legal Guardians:** It is the policy of Chota Community Health Services that all children (minors) seeking treatment be accompanied by a parent/legal guardian during the first office visit. After the initial appointment, a child may be seen in most cases without the parent/legal guardian present if this consent form is filled out and maintained in the minor's record. ***However, patients under the age of 16 years scheduled to see our Psychiatric Mental Health Nurse Practitioner must be accompanied by a parent/guardian at all times .***

I am legally authorized and do hereby give permission for my child to be medically evaluated and treated at Chota Community Health Services in my absence. I understand that it may be necessary to perform diagnostic tests (for example, a throat culture or blood test) and administer injections or shots (for example, steroids or antibiotics) in the course of the evaluation and treatment. I accept responsibility for provider charges, x-rays and laboratory fees.

This consent applies to: (1) Complete provider check-up (including blood and urine samples); (2) Screenings including but not limited to: hearing, vision, scoliosis, and blood pressure; (3) Immunizations; (4) First aid and emergency care; (5) X-ray; (6) Laboratory services (drawing blood or urine samples); (7) Prescription and treatment for illness which may include in-house injections or shots; (8) Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office; and (9) Counseling service.

My child may be accompanied by one of the following authorized caregivers:

Name: ____________________________________________Relationship:_______________________
Name: ____________________________________________Relationship:_______________________
Name: ____________________________________________Relationship:_______________________

I ________________________ give permission for the provider to share any relevant health information with the persons listed above. **This consent will remain on file and active until the minor reaches the age of majority (18 year in Tennessee) or until updated or withdrawn in writing by the parent/legal guardian. *Only the parent or legal guardian can make changes to this form.**

_______________________________________ _______________________
Child's Full Name Child's Date of Birth

Mother's Name Printed: _________________________ Father's Name Printed: _____________________

______________________________ ________________________ _______________________
Parent or Guardian Signature Parent or Guardian Name PRINTED Date

***If this form is filled out by the guardian, proof of guardianship must be on file.*** ***<u>Staff initials verification of guardianship:</u>*** _______

**OPTIONAL:** I am giving permission for my child to present without an authorized caregiver if he/she **<u>is 14 years of age or older</u>** and is aware of his/her own health conditions. ***CCHS may need to contact the parent by phone.***

______________________________ ________________________ _______________________
Parent or Guardian Signature Parent or Guardian Name Printed Date