ALOMERE HEALTH

Here for Life

MRN: _____

Consent for Medical and/or Emergency Treatment of Minor

I/we _____, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, anesthesia, surgical and medical treatment and blood transfusions, by medical providers, hospitals or their authorized designees, as may in their professional judgment be necessary to provide for the medical, surgical or emergency care of my/our minor child

_____ _____ _____

(relationship) (hereafter dependent) - Full Name (DOB)

during my absence or when accompanied by another adult (listed below).

I/we further give my/our consent to Alomere Health, Alexandria Clinic, Lakes ENT and Heartland Orthopedic Specialists (hereafter referred to as "caregiver")who will be caring for my dependent to arrange for routine or emergency medical and/or dental care and treatment necessary to preserve the health of my/our dependent.

If medical care becomes needed, I/we give permission to the caregiver to make such decisions regarding such treatment as deemed appropriate by the medical provider, hospital or their authorized designee without delay. In furtherance of any treatment decisions to be made by the caregiver on my/our behalf for the benefit of my/our dependent, I/we authorize the caregiver to request, obtain, review and inspect any and all information bearing upon my/our dependent's health and relevant to any such decisions to be made respecting such treatment.

I/we acknowledge that no guarantees have been made as to the effect of such examinations or treatment on the condition of my/our dependent and that I am (we are) responsible for all charges in connection with the care and treatment rendered to my/our dependent during this period.

_____ I/we consent to my/our dependent being treated alone, without a parent or legal guardian present.

_____ I/we consent to my/our dependent to being treated with another adult present:

Adult Name: _____ Relationship: _____ Contact Info: _____

Adult Name: _____ Relationship: _____ Contact Info: _____

Adult Name: _____ Relationship: _____ Contact Info: _____

Adult Name: _____ Relationship: _____ Contact Info: _____

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Parent/Legal Guardian Date

This consent is effective and will be retained in your dependent's medical record for a period of one year (12 months) from the date signed unless earlier cancelled in writing. Please contact us should you have questions in regard to this consent.

Our organization complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability or sex.