MAYO CLINIC

Consent to Treat Unaccompanied Minor

Form content retained in medical record.
Route to HIMS Scanning.

TO BE SCANNED

Instructions: It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal decision maker cannot be present prior to treatment. Review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child. This consent applies only to routine medical care (for example, general examinations, vaccinations, minor illnesses) and does not authorize invasive diagnostic or treatment procedures, which require specific consent, absent an emergency. Be advised that protected patient health information may be shared with the designated decision maker to facilitate informed decision making.

Authorization

I/We have the legal right to preauthorize this facility to deliver medical treatment to my/our child. I/We request and authorize (provider or health care facility) _____

and its personnel to deliver medical care to my/our child listed below:

Child Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*
Medications	
Allergies	
Our family receives ongoing care from (provider or health care facility)	

Limitations

Identify the type of medical services for which this authorization is given.
_____

Identify the time frame for this authorization **From** _____ *(mm-dd-yyyy)* **Through** _____ *(mm-dd-yyyy)*

(This consent will be valid for one year from date of signature unless stated differently.)

I/We understand I/we may revoke this consent at any time in writing to (provider or health care facility): _____

Contact Information

If urgent medical care is needed, first try to contact me/us regarding the health care of my/our child at the following phone number(s).
If you are unable, for any reason, to contact me/us, then you may rely on the designated decision maker for consent.

Parent 1 Phone(s)			**Parent 2 Phone(s)**		
Daytime	Evening	Mobile	Daytime	Evening	Mobile

Signatures

Parent or Legal Guardian 1 Signature ▶	Date *(mm-dd-yyyy)*	Time *(hh:mm)*	☐ am ☐ pm
Parent or Legal Guardian 1 Printed Name *(First, Middle, Last)*			
Parent or Legal Guardian 2 Signature ▶	Date *(mm-dd-yyyy)*	Time *(hh:mm)*	☐ am ☐ pm
Parent or Legal Guardian 2 Printed Name *(First, Middle, Last)*			

☐ Phone Conversation with parent or legal guardian	Clinic Representative Signature ▶	Date *(mm-dd-yyyy)*
	Clinic Representative Printed Name *(First, Middle, Last)*	Time *(hh:mm 24-hour clock)*