RALEIGH CAPITOL
EAR, NOSE & THROAT

CONSENT FOR TREATMENT OF A MINOR

TEL: 919.787.1374
FAX: 919.571.8135
RALEIGHCAPITOLENT.COM

Patient Name: _____ DOB: _____

Thank you for entrusting the care of your child to our practice. To provide the best quality of care for your child we require that the parent or legal guardian accompany the child to appointments. We realize that your child may need to be seen for an acute sick visit and the parent or legal guardian may be unable to be present or minor capable of driving presents by him or herself. By completing the information below we will be able to meet the needs of your child during your absence.

In the absence of the parent or legal guardian, I give the person(s) listed below permission to seek medical care and treatment for my child. I also realize that the person listed below may have access to pertinent protected health information if medically necessary. These individuals will be asked to present identification at the time of the visit. If someone other than these persons listed below brings in your child, we will attempt to contact the parent or legal guardian for verbal permission to treat.

	NAME	RELATIONSHIP	PHONE
1.			
2.			
3.			
4.			

For Patients 16 years and older ONLY:

Yes ___ No ___ patient listed above may present and be treated unaccompanied by an adult.

Please be sure the person accompanying your child has the pertinent information regarding your child's illness in order to provide the highest quality of care.

_____ _____ _____
Signature (by typing my name I am electronically signing this document) Relationship Date

Parent(s) or Legal Guardian(s) contact information:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Home Number: _____ Home Number: _____

Cell Number: _____ Cell Number: _____

Work Number: _____ Work Number: _____