Consent for Treatment of a Minor

Minor's full name: _____ Date: _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy Age: _____

Medical record no.: _____ Date of visit: _____ dd / mm / yyyy

BEFORE YOU USE THIS FORM

State law decides who can consent

Who may consent for a minor, and which services a minor may consent to alone, are set by state law. Most states let minors consent independently to some care - commonly sexual health, substance use treatment and mental health - and many recognise emancipated or mature minors. Confirm your state's rules and your organisation's policy before relying on this form.

1. PARENT OR LEGAL GUARDIAN

Full name: _____ Relationship to minor: _____

Address: _____ Home phone: _____

Mobile phone: _____ Email: _____

Legal authority to consent

◯ Biological or adoptive parent ◯ Legal guardian (documentation attached) ◯ Court-appointed custodian (order attached)
◯ Other (describe below)

If other, describe the legal basis and attach documentation

2. SCOPE OF CONSENT

I consent to the following for my child

- ☐ Examination and assessment
- ☐ Immunisations
- ☐ Laboratory tests
- ☐ Referral to a specialist
- ☐ Anaesthesia or sedation if required
- ☐ Routine treatment and procedures
- ☐ Prescription of medication
- ☐ Imaging
- ☐ Emergency treatment if needed

Any treatment I do NOT consent to

Known allergies: _____ Current medication: _____

Relevant medical history: _____ Primary care provider: _____

3. IF A NON-PARENT WILL ACCOMPANY THE CHILD

Complete this section only if someone other than the parent or guardian will bring the child to appointments and may need to authorise care.

Authorised adult's name: _____ Relationship: _____

Phone: _____ Date of birth: _____ dd / mm / yyyy

This adult may

◯ Accompany only - may not consent ◯ Consent to routine treatment ◯ Consent to routine and emergency treatment

Authority valid from: _____ dd / mm / yyyy **Authority valid until:** _____ dd / mm / yyyy

Specific appointments only: _____ **Limitations:** _____

4. EMERGENCY CONTACTS AND DURATION

Emergency contact 1 name: _____ **Phone:** _____

Emergency contact 2 name: _____ **Phone:** _____

This consent is valid

◯ For this visit only ◯ For this course of treatment ◯ Until withdrawn in writing ◯ Until a specified date

Specified end date: _____ dd / mm / yyyy **Insurance / payer:** _____

Policy number: _____ **Preferred pharmacy:** _____

5. ACKNOWLEDGEMENT AND SIGNATURE

I confirm that

- ☐ I have the legal authority to consent to care for this child
- ☐ I have had the opportunity to ask questions and they were answered
- ☐ I understand I may withdraw this consent at any time, in writing
- ☐ The information I have given is accurate to the best of my knowledge
- ☐ I understand that confidentiality rules may apply to some services my child receives

Parent or guardian signature
Printed name: _____

Witness signature
Date: _____ dd / mm / yyyy **Witness printed name:** _____

Date: _____ dd / mm / yyyy

Older minors

Where the minor is old enough to take part in the decision, record their assent as well as the parent's consent. Where state law lets this minor consent independently to the service being provided, their own consent is the one that governs.

Minor's assent or consent (if applicable)
Printed name: _____ **Date:** _____ dd / mm / yyyy

Clinician signature
Clinician name and credentials: _____ **Date:** _____ dd / mm / yyyy

Sources: General-purpose form. Not legal advice. Confirm your state's consent rules and your organisation's policy before use.