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Sarah D. Culbertson Memorial Hospital

Culbertson Therapy Services

Culbertson Clinics

**Consent to Treat Minor - Without Parent/Legal Guardian Present for Routine Medical Care**

Sarah D. Culbertson Memorial Hospital must receive permission from a child's parent or legal guardian prior to providing treatment for routine medical care and interventions which may include, but are not limited to: Medical evaluations, physical exams, routine immunizations, injections (including Allergy Injections), x-rays, lab work, (examples: throat or nasal swabs, blood draws, urine catheterizations, wart treatment with liquid nitrogen, minor burns, minor suturing of lacerations). This form provides the legal permission to (depending on the minor's age) either treat without an adult present (Section A), or with a designated adult present (Section B)

**Patient's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
Last First Middle

**Allergies:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Chronic Conditions:** \_\_\_\_\_

**Section A (ONLY for child at least 16, but not 18 years old)**

*Authorization to treat your minor child in case you or your designated representative is unable to accompany your child to one of his/her visits: I, (print your name) \_\_\_\_\_ grant Culbertson Memorial Hospital permission to assess and treat the aforementioned minor without an adult present. I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.*

**Section B (for child under 18 years old)**

*Delegation of authority for medical treatment of a minor child to the designated representative indicated below: I, (print your name) \_\_\_\_\_ grant Culbertson Memorial Hospital permission to assess and treat the aforementioned minor in the presence of either of the following adults (you may choose more than one) either of whom is authorized to approve treatment:*

\_\_\_\_\_  
Name Relationship to Patient

\_\_\_\_\_  
Name Relationship to Patient

I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered.

Note: A parent/legal guardian **MUST** be present for a minor patient's first visit with Culbertson Memorial Hospital, Therapy Service or Culbertson Clinics.

This authorization is valid for:  Date \_\_\_\_\_ **VALID FOR ONE VISIT ONLY**

**Please Note:** Insurance card(s) and co-pay amounts (if applicable) must be presented at each visit.

**AUTHORIZED BY:** \_\_\_\_\_ **Date Signed:** \_\_\_\_\_  
Parent or Legal Guardian

**Emergency Contact Phone:** \_\_\_\_\_ **Phone #2:** \_\_\_\_\_

*(Note: In accordance with Illinois State Law 410 ILCS, minors may consent to certain medical treatment without obtaining consent of a parent or legal guardian).*