Red Cedar Valley Medicine, PLC

Kids First Immediate Care

Consent To Treat Minor Form

This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine medical care and services.

I hereby appoint: _____ (Name) _____ (Relationship)

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As a decision maker to consent to and authorize routine health care treatment and services for my child listed below.

☐ Check here if you authorize any adult, including a stepparent, accompanying the child to be a decision maker who may consent to and authorize medical care, treatment or services for and to be involved in, the care of a minor child.

I understand medical care, treatment and services may include, but are not limited to: medical evaluation, physical exam, immunizations, x-rays, and diagnostic lab work. I hereby empower and grant the decision maker(s) appointed above, permission to consent to and authorize medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected health information directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. I further understand that if transfer of my child to a hospital or emergency room is necessary, I authorize the decision maker(s) appointed above to consent for the hospital or emergency room treatment for my child in my absence.

First Middle Last

_____ Child's Name

_____ Date of Birth

Parental contact information for questions regarding treatment:

_____ Parent / Guardian's Name

_____ Parent / Guardian's Name

_____ Main Phone

_____ Main Phone

_____ Cell Phone

_____ Cell Phone

I understand there is no obligation to contact me if the decision maker consents to the care. The individual appointed as decision maker herein is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization is valid for one year (1) following the date signed below unless withdrawn in writing to Kids First Immediate Care or Red Cedar Valley Medicine, PLC.

_____ Signature of Parent of Legal Guardian

_____ Witness

_____ Date

_____ Date