



# Stanly Health Services

## Consent for Minor to Receive Health Care Treatment at Stanly Medical Services

Name of Minor Child: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

My name is \_\_\_\_\_, and my relationship to the minor child is:

- I am the natural or adoptive parent having legal custody;
- I am the legal guardian; or
- I am appointed as the minor child's Health Care Agent.

I give my consent for the above-named minor child to receive health care treatment at Stanly Medical Services when I do not personally accompany the child.

I authorize the following adult(s) to act in my place (*in loco parentis*) to give consent for my minor child to receive health care treatment at Stanly Medical Services in my absence:

<i>Print Name &amp; Relationship</i>	<i>Address</i>	<i>Telephone</i>
_____	_____	_____
_____	_____	_____

Although the above-named adult(s) may act in my place to give consent for my minor child to receive health care treatment at Stanly Medical Services in my absence, I would like Stanly Medical Services to notify me if my child requires emergency treatment.

This consent shall be effective from today until the earlier of the following:

- I provide otherwise to Stanly Medical Services, or
- \_\_\_\_\_  
*Enter date*

I understand that I may accompany the above-named minor child to Stanly Medical Services at any time and provide consent for healthcare treatment for the child. I further understand that despite this authorization, I will remain responsible for payment for any healthcare treatment Stanly Medical Services provides to my minor child.

This consent is for treatment which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power, as follows:

- (i) To provide for such health care at any other institution or hospital, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and
- (ii) To consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to any agent named herein.

_____	_____	_____
Custodial Parent/Guardian/Agent Signature	Date	Time

_____	_____	_____
Custodial Parent/Guardian/Agent Signature	Date	Time

