

**Consent to Treat Minor Children Unaccompanied by Parent or Guardian**

**\*Must be completed whenever minor is seen unaccompanied for a new issue.**

(Please print all information )

Date: \_\_\_\_\_

Pt Account Number: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian : \_\_\_\_\_ Parent/Guardian Phone Number: \_\_\_\_\_

Reason for visit(s) \_\_\_\_\_ Provider (Team)/Department: \_\_\_\_\_

As the parent/guardian of the above-named minor, I give consent for CNOS to evaluate and treat without my presence:

- I understand that this consent is only for this diagnosis/episode of care.
- I understand that I must be present to consent for any invasive procedures.
- I understand that I will be required to be present or provide a new consent if follow-up diagnostics are necessary or care is needed from a different provider/department.
- I understand that circumstances may develop during care that may require the physician/provider to contact me.
- I understand that seeing the minor without my presence, even with my consent, is at the discretion of the medical professionals providing care and I may be requested to attend appointments at any time.
- I understand that this consent may be revoked by myself or CNOS at any time.

Parent/Guardian Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

**\*Telephone consent was obtained by contacting the guardian at the number listed above. The terms of this consent were discussed with the parent/guardian and they express verbal agreement and desire for the minor to be seen without their presence.**

**Date: \_\_\_\_\_ Time: \_\_\_\_\_**

**Witness #1: \_\_\_\_\_ (staff member signature) Printed Name: \_\_\_\_\_**

**Witness #2: \_\_\_\_\_ (staff member signature) Printed Name: \_\_\_\_\_**