Reset Form

galion city HEALTH DEPARTMENT

113 Harding Way East
Galion, Ohio 44833

Phone 419.468.1075
Fax 419.468.8618
www.galionhealth.org

**Consent to Treat Minor Child**

(One Child Per Form)

Parent or legal guardian consent must be provided for treatment of a child (minor patient under the age of 18). We understand there are times that it may not be possible for you to accompany your child to each visit and it may be more convenient to authorize another adult to get treatment/care for your child without being present. Therefore, the providers in this office will accept the below authorization to treat your child. If you wish to authorize treatment/care to your child when another adult brings your child in, this authorization must specify the name of the adult 18 years of age or older who is authorized to bring your child in for treatment/care. This authorization will only be in effect for the appointment date listed below.

Please print all information

Name of Minor Child: _____ Child's Date of Birth: _____

Name of Consenting Parent/Legal Guardian: _____

Name of Adult Authorized to Obtain Treatment/Care for Child: _____

I, as the parent/legal guardian of the minor child do hereby consent to treatment/care at the Galion City Health Department and hereby authorize the adult named above to obtain treatment/care for the minor child while said child is in said adult's care. I understand that all age-appropriate, CDC recommended immunizations will be offered during this visit.

Since the adult named above is involved in my child's health care, I further authorize that the providers can give and discuss with the adult protected health information (PHI) about my child and understand that the adult listed above will be responsible for conveying any such PHI given by or discussed with the providers to me.

This authorization is effective for the day of _____.

_____

Signature of Parent/Legal Guardian

This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address: _____

Mother's Name: _____ Phone: _____

Father's: Name: _____ Phone: _____

Allergies to drugs or foods: _____

Medications or Other Pertinent Information: _____

_____

***This consent form must be taken with the child to the Galion City Health Department when the child is taken for treatment/care.***