BLACK HILLS PEDIATRICS, L.L.P.
MEDICAL CONSENT FORM FOR TREATMENT OF UNACCOMPANIED MINOR

______________________________ ______________

PATIENT/CHILD NAME **DATE OF BIRTH**

► UNACCOMPANIED CHILD ◄

Many times parents will send children who are old enough to drive to the clinic without the parent or legal guardian present. If your child does now, or will be coming to the clinic by themselves in the future, please sign the consent below.

Failure to have consent on file except in emergency situations may delay treatment while we attempt to obtain your consent.

I, the undersigned, as the parent or legal guardian hereby authorize such diagnostic, medical, and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and Black Hills Pediatrics, L.L.P., and its employees shall not be responsible in any way for the consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery in so far as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

This consent expires in 1 year unless revoked in writing. As parent/legal guardian, I give consent for my child to be treated if I have not accompanied him/her. I will be responsible for all charges not covered by insurance.

______________________________ ______________

Signature of Parent or Legal Guardian Date

______________________________ ______________

Print Name Relationship

Complete this section if you wish to revoke this authorization:

I revoke this authorization effective ________________ (date).

______________________ ______________________

Signature Date

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Print Name

Revised 4/1/14