Consent to Treat for
Minor Without Parent/Guardian

Child's Name: _____ DOB: _____

I, _____ grant Knox County Health Center
Parent/Guardian Name

permission to examine, treat, administer immunizations, administer medication, provide general medical assessment and care, and dental service that may include fluoride treatment, restoration, or tooth extraction to my child in my absence. This Consent to Treat is granted from parent or guardian signature date and expires on _____.
Expiration Date of Consent

Ms/Mrs/Mr _____, is at least eighteen years of age and is the
Name of Adult Accompanying Child

minor patient's _____. I also grant this individual permission
Relationship to Child

to make decisions regarding my child's treatment if necessary should an emergency arise and I am unreachable. I understand payment is expected at the time of treatment.

Insurance: _____ Policy/Member Number: _____

Parental contact information for questions regarding treatment of child:

Parent/Guardian Name: _____

Phone: Cell: _____ Home: _____ Work: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian Authorization: _____ Date: _____

Office Use:
Adult Identification Confirmed: ☐ *Driver's License* ☐ *Photo ID* ☐ *Other* _____

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