Heartland Women's Healthcare

Medical Consent for Treatment of a Minor Child

I, _____, the ( ) parent or
(Printed Parent's or Legal Guardian's name)

( ) legal guardian of_____,
(Printed Child's full name)

born on _____/_____/_____, hereby authorize Medical treatment in my absence.
(Month) (Day) (Year)

The power, which I confer, is specifically limited to health care decision making by the providers at Heartland Women's Healthcare and may be exercised on my child's behalf for:

- ☐ Medical Examination(s)
- ☐ Treatment(s)
- ☐ Immunizations/Injections
- ☐ All

This document is effective for the above medical service(s) on:

_____or _____to_____
(Exam Date Only) (Date Range – not to exceed 6 month)

I, _____, have signed my
(Printed Parent's or Legal Guardian's name)

name to this medical consent authorization on this _____, day of _____, 20_____.
(Date) (Month) (Year)

_____ _____
(Parent/Guardian Printed Name) (Signature)

_____ _____/_____/_____
Relationship (Mother/Father/Foster Parent/Legal Guardian) Date

Witnessed by:

_____ _____/_____/_____
(Witness – Printed Name) Date

_____
(Witness – Signature)