CONSENT TO MEDICALLY TREAT A MINOR/VULNERABLE ADULT

I ____________________________________ do hereby request and authorize the
print name of parent/guardian/personal representative

provider practice staff to perform necessary services for _____________________________.
Print name of patient

Patient DOB: ____________________

Service provided: ____________________________________

In the event that a reaction takes place while the patient is at this facility, I give my permission to treat the above named patient as the clinic provider deems necessary.

I also consent to have the above named patient comply with clinic guidelines of waiting 20 minutes after an injection. I understand it is expected to check with the nurse or medical assistant before leaving the clinic facility.

__________________________________ ______________

Signature of Parent/Guardian/Personal Representative Date

Consent for this service must be renewed annually.