SWEDISH PHYSICIAN DIVISION

Permission To Treat Minor

TO THE PARENTS OF _____

You and your child's physician have discussed a proposed course of treatment for _____ . You have indicated,
(Name of Child)
and your doctor concurs, that you wish your child to assume the limited responsibility of coming to our office for this treatment unaccompanied.

Accordingly, we ask you to indicate by signing below that we have your consent to administer to your child the following on an ongoing basis (check as pertinent):

- ☐ series of allergy shots
- ☐ immunization updates
- ☐ yearly physical exams for camp, athletics, or school
- ☐ follow-up of an injury
- ☐ cast check and removal
- ☐ suture removal
- ☐ urgent care while we are attempting to contact you
- ☐ other

You are acknowledging by your signature that the risks, benefits, and alternatives to the treatment(s) or examinations checked above have been explained to you (including the alternative of no treatment or examination); that you have had the opportunity to ask questions; that your questions have been answered; and that you agree to pay for these examinations or treatments.

The physician will attempt to contact you directly for discussion of any unusual or different findings, or if there appears to be a need to change the treatment plan.

Please also feel free to call us if you should have any questions or concerns in the future. You must revoke this consent in writing prior to your child's scheduled appointment; this should be mailed or given directly to us.

_____ _____
Parent Date

_____ _____
Parent Date

Signature is only valid for one year.

NOTE: Parent with whom the child lives should sign this form. If you are separated/divorced with a decree which authorizes consent, or some other special legal circumstances exist, please place a copy of pertinent legal papers in your child's medical records.