

Medical Consent Form for Treatment of a Minor with Temporary Guardian

Patient Information:

- Name of Minor: ______
- Date of Birth: [MM/DD/YYYY] _____
- Address: ______

Parent/Guardian Information:

- Name of Parent/Guardian: ______
- Relationship to Minor: ______
- Contact Number: ______
- Email Address: ______

Consent to Medical Treatment

I, [Name of Parent/Guardian], hereby authorize Select Urgent Care and its medical staff to provide medical care to my minor child (listed above), as may be deemed necessary or advisable in the diagnosis and treatment of his/her ailments. I understand that this consent includes routine diagnostic procedures and medical treatment as directed by the attending physician(s).

Scope of Authorization:

- Routine diagnostic tests and procedures
- Administration of necessary medications and treatments
- Performance of emergency medical treatments
- Referrals to and treatment by specialists, as deemed necessary
- Collection and storage of medical specimens and data for diagnostic purposes

Temporary Guardianship (if applicable):

In my absence, I (Parent/Guardian) appoint the below listed individual as temporary guardian to make health care decisions on behalf of my child, only if I am unreachable at the time of treatment decision.



Name of Temporary Guardian: _____

Relationship to Parent/Guardian and/or Minor: ______

Contact Number: _____

Acknowledgment and Signature:

I certify that I am the parent/legal guardian of the minor named above, and I have legal authority to provide this consent for medical treatment. I have read and understand the terms of this consent form, and I am aware that by signing this form, I am giving legal consent for the treatment of the minor by the medical professionals at Select Urgent Care under the described conditions.

Signature of Parent/Guardian: ______ Date: _____

Duration of Consent:

This consent is valid 12 months from the above listed date, unless otherwise revoked in writing by the undersigned.