Black River Health

PATIENT STICKER

TREATMENT OF MINORS IN PARENT/GUARDIAN ABSENCE

PURPOSE: To comply with Wisconsin law, Black River Health requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by the court) consent to the care and treatment of minor children. In the event that a parent or legal guardian is unable to consent to care, the parent/legal guardian may delegate the right to consent to another adult. In the event a minor child presents for a non-urgent medical appointment without a parent or legal guardian or a signed consent, treatment may be denied. Adolescents may seek care under some instances without parental consent.

PATIENT INFORMATION

Child's Name: _____ Date of Birth: _____

DELEGATE RIGHT TO CONSENT TO TREATMENT OF MINOR TO ANOTHER ADULT (APPOINTEE)

I, _____, authorize:
(Full printed name of parent or legal guardian)

Appointee Name: _____ Appointee Relationship to Patient: _____

Appointee Address: _____ Appointee Phone Number: _____

to consent to routine medical care for my child, _____, as indicated below.
(Full printed name of child)

TO CONSENT CHECK ALL THAT APPLY:

☐ Medical treatment or mental health treatment including immunizations, lab work, and other diagnostic tests, but not including any surgery or other procedures which require anesthesia (except local anesthetic)

☐ Pregnancy care including prenatal care, the delivery of the infant, and the post-partum care

☐ Contraception care

☐ Pregnancy testing

THIS CONSENT IS VALID FOR THE PERIOD:

☐ One visit only on ___ / ___ / _____ (MM / DD / YYYY)

☐ From ___ / ___ / _____ to ___ / ___ / _____ (MM / DD / YYYY) (Not to exceed 1 year)

SIGNATURE:

Parent/Legal Guardian Signature: _____ Date: _____

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TREATMENT OF MINORS IN PARENT/GUARDIAN ABSENCE

CONSENT FOR MINOR TO ATTEND APPOINTMENTS UNACCOMPANIED

I, _____, give consent for my mature minor child (14 years or older),
(Full printed name of parent or legal guardian)

_____, to attend and receive routine medical care
(Full printed name of child)

unaccompanied in my absence, as indicated below.

TO CONSENT CHECK ALL THAT APPLY:

☐ Medical treatment or mental health treatment including immunizations, lab work, and other diagnostic tests, but not including any surgery or other procedures which require anesthesia (except local anesthetic)

☐ Pregnancy care including prenatal care, the delivery of the infant, and the post-partum care

☐ Contraception care

☐ Pregnancy testing

THIS CONSENT IS VALID FOR THE PERIOD:

☐ One visit only on ___ / ___ / _____ ☐ From ___ / ___ / _____ to ___ / ___ / _____ (Not to exceed 1 year)
MM DD YYYY MM DD YYYY MM DD YYYY

SIGNATURE:

Parent/Legal Guardian Signature: _____ Date: _____