

Patient name			
MHN	DOB	Age	Gender

Treatment of Minors in Parent/Legal Guardian Absence

Consent

To comply with Wisconsin law, Marshfield Clinic requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to care the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

I/We (parent's name) _____ authorize

Appointee's name _____

Relationship _____

Appointee's address _____

Appointee's phone number _____

to consent to:

- Emergent or urgent care at Marshfield Clinic when I cannot be reached to include mental health treatment.
- Medical, mental health treatment and dental care at Marshfield Clinic including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia, except for a local anesthetic.
- Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic.

for my child:

Child's name _____ Child's MHN _____

during the period:

- Date (month/day/year) ____ / ____ / ____ to ____ / ____ / ____
- For a maximum period of 1 year

Marshfield Clinic providers should attempt to contact me before providing care at the following numbers:

Home phone _____ Work phone _____ Cell phone _____

I further agree to reimburse Marshfield Clinic/health care provider for the cost of rendering these services to the extent that my insurance does not pay for these services.

Patient signature (person authorized to consent for patient) (relationship)

Child's parent/legal guardian address Date (month/day/year)