

Tus neeg mob lub npe Patient name			
MHN MHN	Hnub yug DOB	Muaj tsawg xyoo Age	Poj niam los txiv neej Gender

Tso Cai Kho Rau Cov Menyuum Uas Tsis Tau Muaj Hnub Nyoo (Siv Ib Zaug Xwb)**Keu Tso Cai**

Nploo 1 ntawm 2

Consent - Treatment of Minors - Limited (One Time Use)

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Qhov yuav kom ua raws li txoj kev cai lij choj hauv Wisconsin, Marshfield Clinic/Family Health Center xav kom tau niam txiv (tsis yog niam tshiab txiv tshiab/niam qhuav txiv qhuav) los sis ib tug neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj (tus neeg saib xyuas uas tsev hais plaub xaiv) tuaj nrog cov menyuum uas tsis tau muaj hnub nyoo (17 xyoo rov hauv) thaum lub sij hawm lawv tuaj kho mob/kho hniav. Puas hlwb yog thaum uas niam txiv los sis tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj tuaj tsis tau nrog nws tus menyuum uas tsis tau muaj hnub nyoo ntawd mus kho mob/hniav/puas hlwb, tus niam txiv los sis tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj yuav tsum tau kos npe rau Daim Ntawv Tso Cai Kho Mob Rau Cov Menyuum Uas Tsis Tau Muaj Hnub Nyoo – Siv Ib Zaug Xwb.

To comply with Wisconsin law, Marshfield Clinic/Family Health Center requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) accompany any minor children (17 years old or younger) to their medical/dental/mental health appointments. In the event that a parent or legal guardian is unable to accompany his or her minor child to a medical/dental/mental health treatment appointment, the parent or legal guardian must sign this Consent – Treatment of Minors – Limited (One Time Use) form.

Niam txiv los sis tus neeg saib xyuas uas tau kev tso cai los ntawm kev cai lij choj lub npe _____
Name of parent or legal guardian

Tus neeg mob lub npe _____
Patient name

Txheeb ze li cas

Tus neeg tso cai _____
Appointee (person authorized to consent)

rau tus me nyuam

Relationship to child

Kuv tso cai rau txoj kev kho mob/kuaj hniav/puas hlwb rau kuv tus menyuum raws li lub sij hawm teem tseg rau nws tom Marshfield Clinic/Family Health Center:

I consent to care and treatment for my child related to his/her medical/dental/mental health treatment appointment at Marshfield Clinic/Family Health Center:

rau thaum lub (hnub tim – hli/hnub tim/xyoo) _____ / _____ / _____
on (date – month/day/year)

yog rau (teem sij hawm kho dab tsi – cov kev pab kho mob tshwj xeeb uas tau kev pom zoo lawm/cov txheej txheem kho mob/cov kev soj ntsuam seb mob li cas/kev txhaj tshuaj) _____
for (reason for appointment – specify approved care/procedures/tests/immunizations)

nrog rau (tus neeg muab kev pab kho mob lub npe) _____
with (health care provider name)

Kuv tus menyuum uas paub tab, hnub nyoo muaj _____ (tsis yau dua 16 xyoo) yuav tuaj kuaj mob/hniav/puas hlwb tau nws ib leeg rau lub sij hawm uas teem tseg rau nws.

My mature child, age (#) (not less than 16) can attend this medical/dental/mental health treatment appointment alone.

