

INFORMED CONSENT FOR TREATMENT OF MINOR CHILD

[] *Unaccompanied Treatment*

I hereby request that treatment be rendered to _____,
a minor child for whom I have legal custody or guardianship. I further request that
treatment be provided **unaccompanied by a parent or legal guardian.**

Specify name(s) of other individual(s) to accompany child to treatment, if any:

[] *Informed Consent for Injections, Vaccines, serums, Toxoids, Immunotherapy:*

I understand that, as with the introduction of any agent into the body, there are potential risks and hazards in connection with injections. **These risks include reactions manifested by rashes, hives, respiratory problems, shock, paralysis, brain damage or even death.** I have been given the opportunity to ask questions about the benefits and risk of injections, alternative therapies, risks of non-treatment, procedures to be used, and the risks and hazards involved and I believe I have sufficient information to give this informed consent for treatment of my minor child, for whom I am authorized to make this request for treatment.

- _____ *Parent/Guardian/Custodian Initial(s)*

Emergency Medical Care

In the event of a medical emergency during an unaccompanied visit, I further give my consent for the medical staff of Georgetown Medical Clinic to **immediately render to my child all medical care deemed necessary in their professional judgement**, including emergency intervention, transport to Georgetown Hospital or Children's Hospital (Brackenridge), and emergency medical, surgical or diagnostic procedures as required.

Parent/Legal Guardian

Parent/Legal Guardian

Date: _____ (Form expires 1 year from date signed by Guardian)

Witness: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____