Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Patient Label

PROXY CONSENT TO TREAT MINORS FORM (Adolescents)

Northern Inyo Healthcare District/Northern Inyo Associates requires a parent or legal guardian to be present at the new patient appointment. We feel it is also important for a parent of a minor child to attend all follow-up visits, but realize this may not be possible. This form may be used to allow an adolescent to receive medical care without their parent or legal guardian present.

In order for us to treat a minor without a parent/legal guardian present, please complete this form:

I, _____ (print name here) am the parent/legal guardian of _____ (print name of minor), currently a minor, whose date of birth is _____.

[ ] I authorize Northern Inyo Healthcare District to provide medical care to my son/ daughter, including, but not limited to: medical evaluation, physical exam, diagnostic imaging, lab work, allergy testing, allergy shots, and intramuscular/inhaled/oral medications.

[ ] I authorize my son/daughter to be seen and evaluated at the Northern Inyo Healthcare District located at Bishop Union High School for medical evaluation, physical exam, lab work, and intramuscular/inhaled/oral medications.

I further understand that, once my child reaches the age of eighteen, and for certain confidential medical or mental health concerns, my consent for treatment is not required.

This consent will remain in effect for one year or until the patient reaches the age of eighteen unless revoked in writing to the medical provider.

Immunizations: We will attempt to contact you at the time of the appointment to discuss any immunizations due. If we are unable to contact a parent or guardian a follow up appointment will be made for immunizations.

Limitations:
Identify any specific limitations on the kinds of medical services for which this authorization is given (if none, state "none").

_____

_____

Please list below contact information for adults who have legal right to make medical decisions for the above listed patient:

Mother Name: _____
Phone: _____
Alternative number: _____

Father Name: _____
Phone: _____
Alternative number: _____

Developed: 11/28/17

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Other (Name): _____
Relationship: _____
Phone: _____
Alternative number: _____

Only one parent's signature is required.

Signature of Parent or Legal Guardian

_____ _____
Signature Date/Time

_____ _____
Signature of Witness Date/Time

Developed: 11/28/17