Blackstone Valley Community Health Care

PARENTAL CONSENT

Patient's Name: _____ Birthdate: _____

Medical Record #: _____

I affirm that I am the parent or legal guardian for the above named minor child. I give consent for my child to receive treatment deemed necessary by the providers of the Blackstone Valley Community Health Care Inc.

If I am unable to accompany my child, I give permission for the individuals named below to escort my child for medical services. I understand that it is encouraged that I am present for my child's annual physical.

The individuals listed below must be 18 years of age or older.

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

Name: _____ Relationship: _____ DOB: _____

I understand that this consent shall be considered in effect until rescinded or revoked, up until the child's 18th birthday, becomes emancipated, the child's guardian changes, or for confidential encounters.

_____ _____ _____
(Print Name) (Relationship) (Date)

_____ _____ _____
(Signature of patient/Legal Guardian) (BVCHC Witness) (Date)

For BVCHC Staff use only

Label goes here

Staff: Please ask for ID when presenting for a visit.

Updated as of March 2019