BLOOMINGTON
PEDIATRICS

306 St. Joseph Drive
Bloomington, IL 61701
Phone: 309-662-0504
Fax: 309-663-7645
www.BloomingtonPediatrics.com

CONSENT TO TREAT AN UNACCOMPANIED MINOR

I _____ give permission to my child _____
(Name of Legal Guardian) *(Name of Child Age 16-17 years old)*
DOB: _____to attend ill OR well visit appointments alone, without the presence of a legal guardian or authorized adult. I authorize treatment for my child in accordance with the policies of Bloomington Pediatrics. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, forms or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays, deductibles and/or coinsurance resulting from the visit. This authorization is effective on _____ and expires _____.
(Today's Date) *(Date Authorization is no longer valid)*

Child's Health Information

Currently prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Allergies, illnesses or other comments: _____
_____
_____

Emergency Contact Information for Parents/Legal Guardians

Where/how can you be contacted in case of emergency? _____
Phone: _____
Comments: _____
_____

Health Insurance Information

*If no change since last accompanied visit, check here **(___)** and skip to Signature.

If Insurance information has changed, please complete the following and plan to send the card with your child for scanning into their record.

Insurance Company: _____ Group Number: _____
Policy Holder: _____ ID Number: _____
Policy Holder Date of Birth: _____
Policy Holder Address (if different than patient): _____

Parent or Legal Guardian's Signature: _____
Date: _____