



**CONSENT TO TREAT AN UNACCOMPANIED MINOR**

I \_\_\_\_\_ give permission to my child \_\_\_\_\_  
(Name of Legal Guardian) (Name of Child Aged 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, healthcare examinations, diagnostic testing, administration of immunizations or any other medical treatment deemed reasonably medically necessary by Bloomington Pediatrics. I agree it is my child's sole responsibility to relay 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. I understand and agree that there are risks with all medical treatment and that Bloomington Pediatrics cannot guarantee that any medical treatment will be successful or without complication such as serious illness, injury or death. This authorization is effective on \_\_\_\_\_ and expires \_\_\_\_\_.  
(Date Authorization is no longer valid) (Today's Date)

**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: \_\_\_\_\_