CONSENT TO TREAT FORM

I, ____, the parent/guardian (circle one) of,
Name & Date of Birth

____, grant permission for the above named patient to receive
Name & Date of Birth

the following care at Krohn Clinic.

- ☐ Routine medical care for the following date/s: ____
- ☐ Routine medical care during my extended absence for the following date/s __________________________________. This shall include any medical conditions or surgical procedures deemed necessary during my absence. I also give permission for the above named patient to be treated at another facility if the transfer is necessary to provide care.
- ☐ Pregnancy care including prenatal care, the delivery of the infant and the post partum care.
- ☐ Contraception care for the following date/s:____
- ☐ Pregnancy testing on the following date:____
- ☐ Other (please describe medical condition and include dates of service:__________________________

____

Date:________________________ **Parent/Guardian:**__________________________________

Time:________________________ **Witness:**____

Verbal Consent ☐ **Second Witness:**___________________________________

Additional Information

Address and phone number of Parent/Guardian:

Allergies or medical conditions of Patient:

Insurance:____ Phone:________________________

Group Number:______________________ Subscriber Number:_________________________________

Policy Holder's Name and Date of Birth:____