DELMONT MEDICAL CARE

CONSENT TO DISCUSS TREATMENT

I _____ give consent to _____Dr. DELMONT / DMC_____ to discuss my medical condition, prognosis and treatment with:

_____

Print name and relationship of person you are allowing

_____

Contact information

X_____ _____

Patient/Guardian/Responsible Party signature Date

☐ Denied

CONSENT TO TREAT A MINOR

For pediatric patients only

NOTE: THIS CONSENT DOES NOT APPLY TO ROUNTINE PHYSICAL EXAMINATIONS AND/OR VACCINATIONS PARENTS/GUARDIANS MUST BE PRESENT

I _____ consent to the treatment of _____

who is a minor, under the age of 18 years old for medical treatment accompanied by:

_____ _____

(Print name of designated adult) Relationship to Patient

_____ _____

Date Signature Parent/ Guardian

CONSENT FOR UNACCOMPANIED MINOR

NOTE: THIS CONSENT DOES NOT APPLY TO ROUNTINE PHYSICAL EXAMINATIONS AND/OR VACCINATIONS PARENTS/GUARDIANS MUST BE PRESENT

I _____ consent to the treatment of _____

who is a minor, under the age of 18 years without being accompanied by an adult, parent and/or guardian

_____ _____

Date Signature Parent/ Guardian