CONSENT TO TREAT MINOR

CONSENT TO BE SCANNED INTO MINOR'S CHART

Valley Medical Weight Control/Loss requires that parents with minor children complete this Consent-to-Treat-Minor form. This form gives legal permission to treat your child, dispense medication, and administer injections, if/when you cannot accompany your child. Valley Medical Weight Control/Loss requires permission from a child's parent or legal guardian before treatment for weight loss. If this form is not completed, a parent/guardian must accompany a minor at each visit to our office. This consent will be active and maintained with your child's medical chart from the date signed until cancelled in writing. If you wish to change the authorization at any time, please feel free to contact us.

Parent or legal guardian must be present during initial visit. Parent or legal guardian will be required to attend with minor in our office every 12 weeks for physician follow up visits or as requested by our physician. If minor is absent from our clinic for a period of 90 days or longer, a physician visit may be necessary. Valley Medical will not start or change a minor patient's medication without first speaking to a parent/guardian.

LEGAL GUARDIANS:

-If the minor is in the custody of a legal guardian, we must have proof of guardianship before treating.

-If a minor must be brought to subsequent appointments without legal guardian, the guardian must sign this authorization form for Valley Medical to treat the minor without the guardian being present.

-As stated above, guardian's presence will be required at specific appointments.

-Valley Medical will not start or change a minor patient's medication without first speaking to guardian.

PLEASE PRINT

I, (Name of Parent/Guardian) _____am the Parent OR

Legal Guardian of (Name of Minor Child) _____,

DOB_____, do hereby consent to any medical care related to weight loss which may or may not include an appetite medication, or B12/Lipotropic injections, which shall be determined by a physician, for the purpose of weight loss for my child's program at Valley Medical Weight Control/Loss.

This authorization will be in effect from the date below until revoked in writing by parent/guardian.

Date: _____

Printed Name: _____

Relationship: _____

Signature of Parent or Legal Guardian: _____