Boston Children's Health Physicians
New York & Connecticut

MINOR CONSENT FOR PATIENT UNDER 18 YEARS OF AGE (NON-EMANCIPATED)

I authorize my child, _____, Date of Birth: _____ / _____ / _____

to be seen at Boston Children's Health Physicians, LLP, Division of _____

1. **Alone or Accompanied to Appointment:**

___ My child may be seen without being accompanied by anyone.

___ My child may be seen only accompanied by:

Name: _____ Relationship: _____

2. **Alone or Accompanied in Examination Room:**

___ My child may be seen and treated in the examination room without being accompanied by anyone.

___ My child may be seen and treated in the examination room only accompanied by:

Name: _____ Relationship: _____

3. **This authorization is valid for the following date or period of time:** _____

By signing this form, I authorize the treating provider to perform any test, procedure, and/or vaccination determined by the treating provider to be medically necessary.

Parent/Guardian Signature: _____ Date: _____ / _____ / _____

Print Name: _____

FOR VERBAL CONSENT, OBTAIN ANSWERS TO #1, 2, AND 3 ABOVE.

Date: ____ / _____ / _____ Time: _____ / _____ / _____

Verbal consent obtained by phone from number (_____) _____ - _____

Name of person giving verbal consent: _____

Relationship to patient: _____

Phone call taken by employee: Name: _____ Signature: _____

Witnessed by second employee: Name: _____ Signature: _____

Summary of consent provided (*please indicate what treatment, test, procedure, and/or vaccination the patient's parent/guardian has authorized*): _____

_____