Athena ID: _____

SOUTHWEST DISTRICT HEALTH

Minor Child Authorization - Blanket Consent for Services

Child's Name: First _____ Middle _____ Last _____

Date of Birth: _____ / _____ / _____ Gender: [ ] Male [ ] Female

Parental/Legal Guardian Authorization for Minor Child

[ ] I give authorization for my child to receive the following service(s) from Southwest District Health without a parent/legal guardian present: *(*Check all that you authorize)*

- [ ] Routine medical care and treatment
- [ ] Sexual and reproductive health
- [ ] Dental care and services
- [ ] Mental health services and treatment
- [ ] WIC - Women, Infants, and Children services
- [ ] Nurse-Family Partnership services
- [ ] Parents As Teachers services
- [ ] Nicotine and Tobacco Cessation services
- [ ] Other: _____

[ ] The following named person(s) shall be authorized to bring my child to appointments in my absence.

_____	_____	_____
Name	Relationship to Patient	Phone Number
_____	_____	_____
Name	Relationship to Patient	Phone Number

Duration of Authorization: *This authorization shall remain valid for one (1) year after the authorization is signed unless replaced by an updated authorization prior to that time. Legal guardians have the right to withdraw authorization at any time.*

I declare under penalty of perjury under the laws of this state that the foregoing information is true and correct.

_____	_____	_____
Parent/Legal Guardian Signature	Printed Name	Date

This institution is an equal opportunity provider.

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