Parental Consent for Treatment

Minor Presenting Alone, or with an authorized Non-Parent/Guardian

I, ___________________________________ (parent/guardian), give permission to Boulder Community Health to treat my child, ____(child's name), DOB _________, in the event he/she presents to the clinic alone, or is accompanied by persons listed below. The persons listed below have my permission to make decisions regarding the care and treatment of the child listed above. I understand that any charges resulting from the visit will be my responsibility. The clinic has my permission to forward pertinent medical and other information from these visits to the insurance plan covering my child if applicable.

Please check one:

_______ This form is valid for one year from date of signature.

_______ This form is valid until the child listed above reached the age of 18.

Names of additional people authorized to make decisions regarding the treatment of my child during routine office visits:

Name:_____________________________________ Relationship:_______________________

Parent/Guardian Signature:_____________________________________ Date:___________

Parent/Guardian Name (please print):____

Updated 4/2023