Hilton Health Care, P.C.
Consent for Treatment of a Minor without Parent Present

I give permission for my child to be medically evaluated and treated at Hilton Health Care, P.C. in my absence. I understand that it may be necessary to perform diagnostic tests, such as a throat culture or blood test, in the course of the evaluation. I accept responsibility for physician charges and laboratory fees.

This consent applies to:

- Complete provider check-up (including blood and urine samples)
- Hearing, vision, scoliosis, and blood pressure screening
- Immunizations
- First aid and emergency care
- Prescription and treatment for illness
- Referrals to an outside agency, such as a hospital or radiology center, for services not provided at the office.

List below any services you do not consent to in your absence:

____

____

My child will be accompanied by:
[ ] himself/herself
[ ] babysitter (name) ____________________________________
[ ] other (name, relationship) _________________________

I give permission for the provider to share any relevant health information with the person who is accompanying my child.

_________________________________ Child's Name

_________________________________ Date

_________________________________ Parent/Guardian Signature

_________________________________ Parent/Guardian Printed Name

_________________________________ Phone Number where Parent/Guardian can be reached

_________________________________ **EXPIRATION DATE** (up to 1 year)