RE: _____ a minor.

Date of Birth: _____

Medical Record Number (Office Use Only): _____

I hereby authorize the credentialed providers of Essentia Health and such assistants as the credentialed provider may designate, to administer ongoing evaluation and treatments to the minor named above for:

_____

Describe condition for which ongoing treatment is required

at such intervals as are necessary for the minor's health. The minor may be evaluated and treated whether the minor presents alone or is accompanied by me or another adult.

In the event the minor experiences a reaction to any treatment or any side effect or unanticipated symptom occurs, I understand you will make every effort reasonable under the circumstances to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful or if the situation requires action without delay, I authorize the credentialed providers and other personnel referenced above to take such action as is medically necessary on the minor's behalf.

MD, PA, CRNA, CNS, NP has explained to me the purpose of the planned course of treatment; the risks and possible side effects, if any; the risks or probable consequences of not undergoing the course of treatment, and the probable duration and outcome. I understand you will contact me if you determine a change in the course of treatment you explained is necessary or advisable and will obtain my consent to any such change in treatment before proceeding with it.

I understand this consent will remain in effect for one year unless I change my mind and withdraw my consent sooner in writing. If I withdraw my consent, I understand it will not affect actions already taken in reliance on my consent.

_____ _____

Date *Signature of parent or guardian authorizing treatment*

_____

Relationship to minor