COOK CLINIC

HEALTH CARE TREATMENT AUTHORIZATION CONSENT FOR CHILDREN UNDER 18

This form is designed for those situations where minors are not accompanied by a legal guardian, parent or adult sibling ("Authorized Person"). This form gives authority to a designated adult (a "Representative") to be present and give consent for health care for a minor child. Health care includes any care, treatment, service, or procedure to maintain, diagnose or treat an individual's physical or mental condition, including admission to a health care facility ("Health Care").

Parents and legal guardians may consent to Health Care for a child under the age of 18. If neither parent is reasonably available to consent, or both decline to act, and there is no court-appointed legal guardian, then an adult sibling (18 or older) may consent to Health Care for his or her minor sibling. Indiana Code Section 16-36-1-5(b).

This form must be signed by a parent or adult sibling of the minor child. It delegates authority to the person(s) named below to be present and to give consent for Health Care for the minor child. **This appointment is effective for one year from the date it is signed by the person who is delegating the authority.**

Minor's Legal Name: _____ **("Minor")**

Minor's Date of Birth: _____

Minor's Address: _____

_____

Delegation of My Authority to Consent to Treatment of A Minor

I, _____, the (☐ parent) or (☐ adult sibling) **(check one)** of the Minor named above, do hereby authorize the individual(s) named below ("Representatives") to consent to any Health Care for the Minor, including but not limited to school or sports physicals, which any Physician or Nurse Practitioner at the Cook Family Health Center, Inc. deems advisable and either provides or supervises. The Representatives named below may not delegate their authority to anyone else.

_____	_____
Date	Signature of Parent or Adult Sibling
Phone:	Printed name of Parent or Adult Sibling:

NOTE: An authorized person or Representative must be present for all immunizations.

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ACCEPTANCE OF APPOINTMENT

(1) REPRESENTATIVE

Printed name: | Phone:

Relationship to Minor:

Acceptance

I, _____, accept the authority given to me above to consent to Health Care for the Minor. I understand that I must act in good faith and in the best interests of the Minor.

_____ _____

Date | Signature of Representative

Witness

I, _____(please print), am 18 or older. I witnessed the signature of the parent or adult sibling above and the Representative.

_____ _____

Date | Signature of Representative

(2) REPRESENTATIVE

Printed name: | Phone:

Relationship to Minor:

Acceptance

I, _____, accept the authority given to me above to consent to Health Care for the Minor. I understand that I must act in good faith and in the best interests of the Minor.

_____ _____

Date | Signature of Representative

Witness

I, _____(please print), am 18 or older. I witnessed the signature of the parent or adult sibling above and the Representative.

_____ _____

Date | Signature of Representative

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