OSF HEALTHCARE

CONSENT FOR CHILD TO OBTAIN HEALTH SERVICES WITHOUT GUARDIAN PRESENT

PREAUTHORIZATION

I, (guardian name)_____, give my consent for (child's full name)_____

_____(Child's Date of Birth)_____to receive the health

care services indicated below at (hospital/office name)_____

_____under the direction of (licensed provider name) _____

_____.

This consent shall begin on_____and remain in effect through_____.

This consent may remain in effect for up to one (1) year from the "begin on" date. If the "through date" is blank, consent will expire one (1) year from the "begin on" date or upon receipt of your written revocation of this consent. This consent form is only to be used for minors between the ages of 12-17.

Please mark the services for which you are authorizing the child to obtain without you present:

_____Assessment, diagnosis, and treatment of minor illness and/or injury
_____Athletic, School and/or Other Routine Physicals
_____Immunizations
_____Routine Allergy Immunotherapy (allergy shots)
_____Behavioral Health Treatment
_____Procedure (Please describe) _____
_____ COVID-19

_____

Phone number where I can be reached during the provision of health services: _____

_____
Authorization Signature – Parent/Legal Guardian

_____
Printed Name – Parent/Legal Guardian

_____
Date/Time

_____
Relationship to Patient

_____
Witness – Mission Partner and/or notary