PriMED PHYSICIANS
Treating You Well.®

# Consent for Treatment Information Sheet

**All PriMed patients under 18 years of age must have consent from their parent or legal guardian before being seen and treated by the doctor.**
We understand that there are times that it may not be possible for you to accompany your child to each visit. Therefore, we will accept a signed consent to treat from the parent or legal guardian for any visit. A written consent must specify the name of the alternate decision-maker for treatment. Treatment includes, but is not limited to, sick and well visits, allergy and antibiotic injections, and vaccine administration. That individual must be over the age of 18 years. The form below can be used for consent to treat.

**Visits for well check-ups and immunizations** are an opportunity to provide education on your child's growth and development as well as to directly address all of your concerns. Many times important details may not be available from caregivers, grandparents or older siblings. Also, during these well visits important immunizations are given. It is important that you understand the risks and benefits of each immunization by reviewing an information sheet for each vaccine given. As physicians, we would PREFER that the parent or legal guardian be present for these visits. **The CDC requires that an adult be present to read the vaccine information sheet immediately prior to the administration of each vaccine.**

**Ohio Law Exception to Parental Consent**
The Ohio law states that there are certain confidential matters which do not require parental consent and for which diagnosis and treatment may be provided with the minor's consent. They are as follows:

- Emergency medical treatment which appears to be necessary for the minor
- Diagnosis and/or treatment of any sexually transmitted disease
- Diagnosis and/or treatment of HIV/AIDS
- Diagnosis/or treatment for a condition believed to be substance abuse
- Pregnancy testing, family planning or birth control request/treatment

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# Alternate Decision-Maker
# Consent for Treatment

This form is for families who are ongoing patients of PriMed Physicians.

I appoint _____ _____,
(Print Name) (Print Address)

_____, who is my child's _____
(Phone number) (Specify nature of alternate's relationship to child)

as (our) alternate decision-maker for consenting to medical care for my child listed below. I have the legal right to delegate such consent to the alternate decision-maker, who is an adult and legally and medically competent to exercise the authority so delegated. Be advised that protected health information may be shared with the alternate to facilitate informed decision making. **This consent is valid until revoked in writing.**

Name _____ DOB _____
(Print child's Name) (Child's DOB)

## Limitations

Identify any limitations on the kinds of medical services for which this consent by alternate is given. If none, state "none."

_____

_____

## Contact Information

I (we) can be reached at the following numbers. If you are unable for any reason to contact me (us), you may rely on the alternate decision-maker for consent.

Parent's Name :_____ Parent's Name: _____

Daytime Phone:_____ Daytime Phone:_____

Evening Phone:_____ Evening Phone:_____

Cell Phone: _____ Cell Phone: _____

_____ _____ _____
(Print Name Parent or Legal Guardian) (Signature Parent or Legal Guardian) (Date)

_____
(Signature Alternate Decision-Maker)

- Attach copy of Alternate Decision-Maker's driver's license.

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