CONSENT FOR TREATMENT OF A MINOR

Patient Name: _____ DOB: _____

Home Address: _____ Phone: _____

Parent/Legal Guardian: _____ Phone: _____

Alt Phone: _____

I. Written or verbal consent from a parent or legal guardian is required for diagnosis and treatment of a minor when not accompanied by a parent or legal guardian.

I hereby give my consent for my above named minor child to receive the following medical treatments at Family Practice Associates of Lexington, PSC without my presence.

- General physical exam and treatment
- General sick exam and treatment
- Labs
- Immunizations and/or allergy shots
- Other: _____

II. Furthermore, in my absence, I authorize the following person(s) to accompany my child for medical treatment at Family Practice Associates of Lexington, PSC. Unless specified by court documents, Family Practice Associates will diagnose and treat a minor child when accompanied by either parent.

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

_____ _____
Name Relationship to Minor

Although the providers at Family Practice Associates encourage open communication between parents and children on all issues, I understand that Kentucky law (KRS 214.185) states that minors may be treated without the consent of the parent or legal guardian for certain conditions, including STDs, pregnancy, alcohol/drug abuse and requires the minor's consent to disclose such information on those specific issues.

_____ _____
Signature of Parent/Legal Guardian Date

_____ _____
Relationship to Patient Witness