Pointe Medical Services, Inc.

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Consent to Treat Minor

Section A: Name of Minor.

First Name:_____Last Name:_____Middle Initial_____
DOB:_____(mm/dd/yyyy)

Section B: Name of Parent or Guardian.

First Name:_____Last Name:_____Middle Initial_____
Relationship to Minor: ☐ Parent ☐ Legal Guardian ☐ Other _____(please specify)

Section C: Consent for treatment in absence of Parent or Guardian.

I authorize the following individual to bring the minor stated in Section A for treatment in my absence:

First Name:_____Last Name:_____Middle Initial_____
Relationship to Patient: _____
Telephone: _____

Section D: Signature of Parent or Guardian. Please present a picture ID to staff.

_____ _____
Signature of Parent or Guardian Date (mm/dd/yyyy)

Section E: Notarize.

Sworn to and subscribed before me this date:_____(mm/dd/yyyy)
State of Florida, County: _____

This individual is personally known to me or produced the following identification:
☐ Drivers License ☐ Military ID ☐ Other_____(please specify)

_____ _____
Signature of Individual (Place Seal Here) Date (mm/dd/yyyy)

Picture ID Presented: _____(initials)
Scanned by: _____(initials)