

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)