



### Consent for Treatment of Minor Child

This completed form will authorize us to:  provide medical treatment.  
 collect and/or perform drug/alcohol screen.

\_\_\_\_\_ of \_\_\_\_\_  
Name of Parent or Guardian Street Address

City of \_\_\_\_\_, County of \_\_\_\_\_, State of \_\_\_\_\_

As the  Mother  Father  Legal Guardian (Circle One,) I hereby give permission for

\_\_\_\_\_, a minor of \_\_\_\_\_ City of \_\_\_\_\_  
Name of Minor Child Street Address

County of \_\_\_\_\_, State of \_\_\_\_\_ who is employed by \_\_\_\_\_

\_\_\_\_\_, to be treated or screened as authorized.  
Employer Name

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concerning the necessity for such surgery, are obtained prior to the performance of such surgery.

\_\_\_\_\_, 20\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

Telephone Authorization \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Witness

### Patient Release of Information

I hereby authorize, direct, and consent to the release of my medical records by or to Methodist Occupational Health Centers, Inc./Workplace Health Services as follows:

TO BE RELEASED TO/FROM:  Parent or Guardian

\_\_\_\_\_  
Minor Signature