BCSC Health Clinic
1950 Doctors Park Drive, Suite C
Columbus, IN 47203
Ph: 812-375-8810
Fax: 812-375-8879

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 Guradian Street Address

City of ________________________, County of ______________________, State of ____________________

As the Mother Father Legal Guradian, (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 BCSC Health Clinic as follows:

TO BE RELEASED TO/FROM:

☐ Parent or Guardian

____
Minor Signature

Updated 7/17/14