

Patient name _____			
MHN _____	DOB _____	Age _____	Gender _____

**Treatment of Minors in Parent/Legal Guardian Absence**

**Consent**

To comply with Wisconsin law, Marshfield Clinic Health System requires that a parent (not step-parent/foster parent) or legal guardian (guardian appointed by a court) consent to the care of minor children. In the event that a parent or legal guardian is unable to consent to the care, the parent or legal guardian may delegate the right to consent to another adult. In the event that a minor child presents for a non-urgent medical/mental health treatment/dental appointment without a parent or legal guardian or a signed consent, treatment may be denied.

I/We (parent's/legal guardian's name) \_\_\_\_\_ authorize:  
 Appointee (person authorized to consent) \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_ Appointee's phone number \_\_\_\_\_  
 Appointee's address \_\_\_\_\_

to consent to – check (✓) all that apply:

- Emergent or urgent care (including mental health treatment) at Marshfield Clinic Health System and affiliates when I cannot be reached
- Medical treatment, mental health treatment or dental care – including immunizations, lab work and other diagnostic tests, but not including any surgery or other procedures which require anesthesia (except for a local anesthetic) – at Marshfield Clinic Health System and affiliates
- Any and all necessary medical/mental health treatment/dental and surgical care and treatment at Marshfield Clinic Health System

for my child (patient's name) \_\_\_\_\_

during the period (not to exceed maximum of 1 year):

- Date (month/day/year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- For a maximum period of 1 year

I/We (parent's/legal guardian's name) \_\_\_\_\_ authorize my driving-age child (patient's name) \_\_\_\_\_ to receive routine care, unaccompanied during the period (date – month/day/year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I/We (parent's/legal guardian's name) \_\_\_\_\_ authorize my child (patient's name) \_\_\_\_\_ to attend physical/occupational therapy appointments unaccompanied during the period (date – month/day/year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Providers at Marshfield Clinic Health System and affiliates should try to contact me before providing care using the following numbers:  
 Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

**I further agree to reimburse Marshfield Clinic Health System health care provider for the cost of rendering these services to the extent that the minor's insurance does not pay for these services.**

Child's parent/legal guardian signature \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Child's parent/legal guardian address \_\_\_\_\_ Parent/Legal guardian phone number \_\_\_\_\_ Signature date (m/d/y) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Send completed form to: Health Information Management, Marshfield Clinic Health System, 2727 Plaza Drive, Wausau, WI 54403 Fax: 715-847-3069 E-mail: mclhim.consent@marshfieldclinic.org**