CAPITAL AREA cahn HEALTH NETWORK

Parental/Legal Guardian Authorization to Treat Minor Child

Until revoked or changed in writing, I_____, as the parent ( ) or legal guardian ( ) of _____, am requesting and giving my permission for the physicians and any other medical personnel of Capital Area Health Network to provide medical services including examination and treatment as they deem necessary for my child (please check):

_____ with only myself (parent/legal guardian listed above)

_____ as long as they are accompanied by any one of the following individuals:

Name	Relationship
_____	_____
_____	_____
_____	_____

_____ alone, without an adult present (applicable to minors aged 13 and older)

This authorization includes necessary bloodwork as well as the administration of any recommended immunizations unless otherwise specified below:

_____

_____

_____

I understand that whoever brings my child (including myself) *must* have photo identification at each visit in order to protect my child's safety and healthcare. I have listed all pertinent information regarding my child's medical history below:

Patient Full Name: _____ Date: _____

Allergies (if no known allergies write "none"): _____

Current medications: _____

Chronic health problems: _____

Signature of Parent/Legal Guardian: _____

In the event of an emergency, I can be reached at: _____

_____

*In the state of Virginia the "Minors' Consent Law" protects the privacy of minors regarding certain aspects of health care. This law gives minors the consent to a range of sensitive health care services including sexual and reproductive health care, mental health services and alcohol and drug abuse treatment. Any information regarding things of this nature may not be disclosed to anyone *including* a parent or legal guardian without the minors consent to do so. Please be assured that Capital Area Health Network will strive to provide the best health care possible for your child as we have their best interest in mind as well.