DePaul Community Health Centers

# Authorization and Consent to Treat in Absence of Parent or Legal Guardian

I, (name of parent/legal guardian) _____, give my permission and hereby consent to have my child (name of child) _____, brought to and treated by DePaul Community Health Centers by the following individual(s) in my absence:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Date of Birth: _____

My permission for the above-named individual(s) allows for the individual(s) to take the following actions: (Check One)

☐ I give permission for the above named individual(s) to seek treatment/vaccine(s) for my child and provide consent for such treatment, as is necessary, if attempts to contact me are unsuccessful.

☐ I give permission for the above named individual(s) to seek treatment/vaccine(s) for my child and provide consent for such treatment, as is necessary, without having to contact me.

Expiration of Permission (Check One):

☐ This form will remain in effect until I request, in writing, to remove or revoke consent, ,and will automatically renew annually.

☐ This form is VALID ONLY during the following timeframe:

Effective Date: _____ Expiration Date: _____

| _____ | _____ | _____ |
|---|---|---|
| Signature of Parent or Legal Guardian | Printed Name | Date |
| _____ | _____ | _____ |
| Signature of Witness | Printed Name | Date |