7692 Eldorado Parkway
McKinney, Texas 75070
972.562.8388 (Phone)

Permission to Treat a Minor in the Absence of a Parent/Guardian

I, _____ hereby give permission for my Minor child _____ Date of Birth _____, to be treated at McKinney Family Medicine. Unless revoked sooner in writing, this consent remains in effect until my child is**:** ☐ **18 years old** ☐ **until the ___of _____, 20___**.

_____ **I give permission** for my minor child to have routine medical care and treatment
Initial

_____ **I give permission** for my minor child to have immunizations, injections, urinalysis, and EKG
Initial

_____ **I give permission** for my minor child to complete a urine drug screen for controlled medication
Initial

_____ **I give permission** for my minor child to have blood drawn for diagnostic purposes
Initial

OR

_____ **I DENY consent** for my minor child to be treated without a parent/guardian present
Initial

I understand that **I am financially responsible for any co-pays and charges** not covered by my insurance which are incurred as a result of this consent for treatment/care.

Signature of Parent/Guardian: _____

Date: _____

Witnessed By: _____