



PERMISSION TO TREAT A MINOR WITHOUT A PARENT/GUARDIAN PRESENT

Brickie Community Health Clinic (BCHC) must receive permission from the student’s parent or legal guardian before providing treatment for an injury or illness that is not life-threatening. This form gives our healthcare providers your consent to assess and treat your student without an accompanying adult present.

I (we) do hereby state that I am (we are) the parent(s) and/or legal guardian(s) of the minor child named below, who resides with me (us) at the address indicated. Under the advice and care of a CCNI physician or advanced practice nurse provider who is licensed to practice in the state of Indiana, I (we) consent to any necessary examination, diagnostic testing, or treatment for my (our) below named child.

Specifically, I (we) consent to each of the services below (**INITIAL** each service that your child may receive from Brickie Community Health Clinic without your presence):

- Physical examination and/or first aid treatment
- Medical and nursing management of acute or chronic illnesses or diseases
- Laboratory testing: including blood sugar, mononucleosis and strep tests
- Immunizations required for school attendance or recommended flu shots
- Sports Physicals
- Mental health screenings
- Mental health counseling
- Nutritional counseling
- Substance abuse screenings
- Pregnancy testing and counseling
- Testing and treatment for sexually transmitted diseases

*Permission to contact student directly for follow up? YES _____ NO _____
*IF YES, Student’s phone number: _____

Parent/Legal Guardian Name(s): _____

Student’s Name(s) _____

Date of Birth: _____ Age _____

Date of Birth: _____ Age _____

Date of Birth: _____ Age _____

Resides at (street address) _____

City/State/Zip Code _____

Parent/Legal Guardian Signature

Date

Relationship to Student

EXPIRES ONE YEAR FROM DATE SIGNED