PICKENS
Urgent Care & Primary Care

CONSENT TO TREAT A MINOR

(if applicable)

Father's Name: _____ DOB _____/_____/_____

Address: _____ City: _____ State: _____ Zip:_____

Phone:_____ (OK to call Y/N)

Mother's Name: _____ DOB _____/_____/_____

Address: _____ City: _____ State: _____ Zip:_____

Phone:_____ (OK to call Y/N)

Guardian's Name: _____ DOB _____/_____/_____

Address: _____ City: _____ State: _____ Zip:_____

Phone:_____ (OK to call Y/N)

Emergency Contacts :

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Please circle all that apply to minor and family :

Divorce, Legal Separation, Custody / Guardianship Restraining Orders, Current Litigation Issues, Probation

Any issues concerning Divorce, Custody, Guardianship, Probation and/or Restraining Orders will require all documents to be presented on first visit to verify any legal issues and/or custody of child. Copies of these documents will be kept with minor's records.

I, (print name) _____ , am the mother/father/legal guardian (circle one) of _____and I authorize Pickens Urgent Care, LLC to provide medical treatment with Pickens Urgent Care, LLC. _____ (initial here)

I, (print name) _____ , authorize the Emergency Contacts to accompany my child, and I authorize Pickens Urgent Care, LLC to provide medical treatment to said minor. I also agree to be legally responsible for any charges said minor may incur during the treatment with Pickens Urgent Care, LLC. _____ (initial here)

Signature :_____ Date :_____

(Must be signed for services to begin)