ELLENBECKER PERSONALIZED MEDICINE

Modern Care, Intentional Focus

CONSENT TO TREAT UNACCOMPANIED MINOR

It may be more convenient to have prior authorization in place so that care may be delivered directly to your minor child if you cannot be present. This consent applies only to routine medical care (e.g., general examinations, vaccinations, minor illnesses) and does not authorize invasive diagnostic or treatment procedures, which require specific consent absent an emergency. Protected health information may be shared with the designated decision maker to facilitate informed care.

AUTHORIZATION

I/We have the legal right to authorize medical treatment for my/our child and hereby request and authorize Beau Ellenbecker, DO and the staff of Ellenbecker Personalized Medicine to deliver medical care to the child listed below in my/our absence.

Child Name (First, Middle, Last): _____ **Birth Date:** _____

Medications: _____

Allergies: _____

Our family also receives ongoing care from (provider/facility): _____

LIMITATIONS

Type of medical services for which this authorization is given: _____

Time frame — From: _____ **Through:** _____

This consent is valid for one year from the date of signature unless otherwise stated above. I/We understand this consent may be revoked at any time in writing to Ellenbecker Personalized Medicine.

CONTACT INFORMATION

If urgent medical care is needed, please first try to reach me/us at the number(s) below. If we cannot be reached, the designated decision maker above may provide consent.

Parent / Guardian 1 Phone(s)

Daytime	Evening	Mobile

Parent / Guardian 2 Phone(s)

Daytime	Evening	Mobile

SIGNATURES

Parent/Guardian 1 Signature: _____ **Date/Time:** _____

Printed Name: _____

Parent/Guardian 2 Signature: _____ **Date/Time:** _____

Printed Name: _____

☐ Consent obtained by phone conversation with parent/guardian (in lieu of signature)

Staff Signature: _____ **Date/Time:** _____

Printed Name: _____