INFORMED CONSENT FOR TREATMENT OF MINOR CHILD

[ ] ***Unaccompanied Treatment***
I hereby request that treatment be rendered to ___________________________________,
a minor child for whom I have legal custody or guardianship. I further request that treatment be provided **unaccompanied by a parent or legal guardian.**

Specify name(s) of other individual(s) to accompany child to treatment, if any:

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[ ] ***Informed Consent*** *for Injections, Vaccines, serums, Toxoids, Immunotheraphy:*
I understand that, as with the introduction of any agent into the body, there are potential risks and hazards in connection with injections. **These risks include reactions manifested by rashes, hives, respiratory problems, shock, paralysis, brain damage or even death.** I have been given the opportunity to ask questions about the benefits and risk of injections, alternative therapies, risks of non-treatment, procedures to be used, and the risks and hazards involved and I believe I have sufficient information to give this informed consent for treatment of my minor child, for whom I am authorized to make this request for treatment.

- ________________________________***Parent/Guardian/Custodian Initial(s)***

Emergency Medical Care
In the event of a medical emergency during an unaccompanied visit, I further give my consent for the medical staff of Georgetown Medical Clinic to **immediately render to my child all medical care deemed necessary in their professional judgement,** including emergency intervention, transport to Georgetown Hospital or Children's Hospital (Brackenridge), and emergency medical, surgical or diagnostic procedures as required.

_______________________________ _______________________________
Parent/Legal Guardian **Parent/Legal Guardian**

Date: __________________________ (Form expires 1 year from date signed by Guardian)

Witness: ____

Address: _______________________ City, State, Zip: ______________________________

Home Phone: __________________________ Work Phone: _________________________