OSF SAINT FRANCIS MEDICAL CENTER

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AMBULATORY HEALTHCARE
PARENTAL CONSENT FOR CHILD TO OBTAIN HEALTH SERVICES
(Pre-authorization)

I, ___________________________________ , give my consent for ___________________________________, D.O.B. ________________, to receive the following health services at ___________________________________ under the direction of Doctor ___________________________________.

This grant of consent shall begin on ________________, and shall remain effective through ________________.

Please indicate the Services consented for:

___ Assessment, diagnosis and treatment of minor illness and injury
___ Athletic and routine physicals
___ Immunizations
___ Routine allergy shot
___ Behavioral Health Treatment
___ Procedure (please describe)
____
____

Phone number where I can be reached during the provision of health services:

___________________________________.
(Must be completed)

____
Authorization Signature-Parent/Legal Guardian

____
Relationship

____
Date