Alpine Medical
SPECIALTY PRACTICES

PERMISSION TO TREAT A MINOR
(UNDER THE AGE OF EIGHTEEN [18])

I hereby give permission to the physicians, physician assistants and nurse practitioners of Alpine Medical and Speciality Practices to perform treatment, including minor surgical, medical and diagnostic procedures emergent or non emergent that would be necessary to treat my child _____for his/her condition.
(name of child) DOB

I understand that I or another responsible and knowledgeable adult should accompany my child for routine care. If this is not possible with teenagers, I hereby give consent to their treatment without a parent being with them.

This permission slip will be used in addition to making an effort to contact parents or legal guardian in the case of an emergency.

The physicians of Colorado Springs Family Practice, PC reserve the right to discuss the results of all testing and treatment with parents of the minor when the physician feels this is necessary for the best care of the minor.

Signed_____ Date_____
Parent or Guardian

Relationship_____

Signature of minor_____ Date_____
(over the age of 12)

Witness_____ Date_____