CAPE MEDICAL GROUP

# Permission to Treat Minor Patient Without Parent/Legal Guardian Present

Cape Medical Group must receive permission, from a child's parent or legal guardian, prior to Providing treatment(s) for preventative care, injury or illness that is non-life threatening. This form provides the Legal permission to (depending on the minor's age) either treat without any adult present (Section A), or with a Designated adult present (Section B)

Patient's Name: _____

Patient's Date of Birth: _____ Today's Date: _____

## Section A (ONLY for child at least 16, but not 18 years old)

*Authorization to treat your minor child in case you or your designated representative are unable to Accompany your child to one of his/her visits for (circle all that apply)*

☐ ***IMMUNOTHRAPY (Allergy Shot) Visits***

☐ ***ACCUTANE FOLLOW-UP Visits***

I, (print your name) _____ grant Cape Medical Group, P.A. permission to assess and treat the aforementioned minor without an adult present. I also agree to be financially responsible for payment of all charges in connection with the care and treatment rendered. I understand that CMG will *only* consent to treat my child for the aforementioned appointments. I understand that an adult must be present for all other visits with the practice.

## Section B (for child under 18 years old)

*Delegation of authority for medical treatment of a minor child to the designated representative indicated Below*:

I, (print your name) _____ grant Cape Medical Group, P.A. permission to assess and treat the aforementioned minor in the presence of either of the following adults (you may choose more than one), who is authorized to approve treatment:

Name: _____ Relation to Minor: _____

Name: _____ Relation to Minor: _____

I also agree to be financially responsible for payment of all charges in connection with the care and Treatment rendered.

**NOTE: A parent / legal guardian MUST be present for a minor patient's first visit with Cape Medical Group.**

This authorization is valid for:

☐ This visit only (date of appointment): _____

☐ Until otherwise revoked

Please Note: Insurance card(s) and co-pay amounts (if applicable) must be presented at each visit.

Authorized by: _____ Date: _____

Parent or Legal Guardian

Emergency Contact Phone #1 _____

Emergency Contact Phone #2 _____

NOTE: Title 13, Chapter 7 of Delaware Code (State Law) allows for exceptions, where a minor has the same capacity as an adult to consent to medical treatment. For more information please visit: https://delcode.delaware.gov/title13/c007/sc01/index.html