



# Myrtle Hilliard Davis

## Comprehensive Health Centers, Inc.



The People We Are Are the People We Serve  
www.mhdchc.org

### Authorization to Treat a Minor Child

Dear Parent/ Legal Guardian:

It is always best for you to accompany your child to all doctor appointments. We understand that there may be times when you must send your child to an appointment when you are unavailable to be present: however, we can only treat your child with your permission. Please complete the area at the bottom of this page. We will keep this form in your child's record for reference. This prevents someone from bringing your child to the doctor without your permission.

Thank you,

MHDCHC Staff

(Please check all that apply)

I, \_\_\_\_\_ give permission for MHDCHC providers and nursing staff to treat my  
(Parent/ Guardian Name)

child and hereby consent to any medical care and the administration of required vaccines determined by the MHDCHC provider to be necessary for the welfare of my child.

☐ I, \_\_\_\_\_ give permission for MHDCHC providers and nursing staff to treat my  
(Parent/ Guardian Name)  
child and hereby consent to any behavioral health services and/or counseling determined by the MHDCHC provider to be necessary for the welfare of my child.

This authorization is effective from \_\_\_\_\_ to \_\_\_\_\_.

\_\_\_\_\_  
(Child's Name)

\_\_\_\_\_  
(DOB)

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(School District/ MHDCHC Staff Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Parent/Guardian Contact Number)

\_\_\_\_\_  
(Parent/Guardian Home Address)

This additional information will assist in treatment if it can be furnished with the consent.

Allergies to drugs or foods \_\_\_\_\_

Past Medical Illness/Past Surgical History or Pertinent Information  
\_\_\_\_\_  
\_\_\_\_\_

Special Medications: \_\_\_\_\_

Child's Provider \_\_\_\_\_

Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

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