



CONSENT FOR MINOR TO COME UNACCOMPANIED TO APPOINTMENT

I _____, am the parent or guardian _____ (legal name of patient). I have the legal right to consent for medical treatment for this child (patient).

I authorize _____ this patient to come to his or her medical appointment, and consent to medical care which is deemed necessary by the physicians and medical providers at MainStreet Family Medicine at the time of the appointment.

Please select which service your child will be seen for at the time of service:

- | | |
|--|---|
| <input type="checkbox"/> Well child check with vaccines | <input type="checkbox"/> Procedures |
| <input type="checkbox"/> Well child check without vaccines | <input type="checkbox"/> Injections (including Immunotherapy) |
| <input type="checkbox"/> Sports Physical | <input type="checkbox"/> Infusions |
| <input type="checkbox"/> Missionary Physical | <input type="checkbox"/> Lab draws |
| <input type="checkbox"/> Sick Visit | |

Please select the Provider for the above appointment:

- Dr. Colten Bracken
- Kody Holt
- Lexi Hartley
- Nurse

Signature of Parent or Guardian

Printed Name

Date

Emergency Contact information for parent/guardian: _____
Phone Number