



RAU FAMILY MEDICINE

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**Minor Consent Form**

Dear Parents:

Below you will find a legal consent to medical care, treatment and/or consultation for you child in case of your absence. In the interest of healthy outcomes, we would like to suggest that you allow us the possibility of developing a confidential relationship with your child. Discussing this agreement with your child may in effect allow a more open discussion within your family of the changes that accompany growth and development, and most importantly the risks that accompany those changes. We realize with little ones this seems like a long way off, but it's probably never too early to consider a child's health and safety.

Please don't interpret this document as discouraging your presence during your child's medical visit. As long as we have your consent to provide care in your absence, we will try to respect whatever choices you and your child make regarding who is present at a medical visit. As always children at different ages will have different capacity for participating in the process.

Please review our choices handout. We will probably offer your child the same decision making experience unless you specifically direct us otherwise at the time of a medical visit.

**Authorization by Parent(s) to Consent to Medical Care,  
Treatment or Consultation during Absence of Parent(s)**

**Parent/Guardian's Name** \_\_\_\_\_

**Child's Name** \_\_\_\_\_ **Date** \_\_\_\_\_

I understand that I may not always be present during an office visit at Rau Family Medicine during which care, treatment, and/or consultation is requested for or by my minor child. In the event that I do not accompany my child, I authorize the physicians and their assistants to treat my child, perform physical examinations on my child, and/or discuss and consult with my child about any medical concerns my child may have.

I accept responsibility for understanding the content of this document. This document is only for the use of Rau Family Medicine.

Without in any manner limiting this agreement, if present and I specifically express my desire, I will be consulted in connection with any medical care, treatment, or consultation rendered for or to my minor child.

**My signature below constitutes my acknowledgement:**

1. That I have read and agree to the above.
2. That I hereby give my authorization and consent to treatment and/or consultation for my child in my absence.

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Parental/Guardian Signature

Date