Patient Label

OSF HealthCare

C0390-1266

PARENTAL/GUARDIAN CONSENT FOR CHILD TO OBTAIN HEALTH SERVICES PREAUTHORIZATION

C0390-10000-22-1266 (Rev. 03/25)

I, (guardian name)_____, give my consent for (child's full name)_____

_____ (child's date of birth) _____to receive the health

care services indicated below at (hospital/office name)_____

under the direction of (licensed provider name) _____.

This consent shall begin on_____and remain in effect through_____.

This consent may remain in effect for up to one (1) year from the "begin on" date. If the "through date" is blank, consent will expire one (1) year from the "begin on" date or upon receipt of your written revocation of this consent.

Please mark the services for which you are authorizing the child to obtain without you present:

_____ Assessment, diagnosis, and treatment of minor illness and/or injury

_____ Athletic, School, and/or Other Routine Physicals

_____ Routine Immunizations: Per the OSFMG Childhood Immunization Schedule List, available upon request. The list goes by the Center for Disease Control (CDC) and the Advisory Committee on Immunization Practices (ACIP).

_____ Other Immunizations: Parent must specify in writing on the line below, may refer to Pediatric Immunization Guide.

_____

_____ Routine Allergy Immunotherapy (allergy shots)

_____ Routine Behavioral Health appointments

_____ Procedure(s): Including ear wax removal/washing, wart removal, suture or staple removal.

Some patient care may require discussion and specific informed consent from the Parent/Legal Guardian; therefore, the office/hospital may contact you before it is able to provide some specific treatments. For example,

- Foreign body removal, drainage of an abscess or other invasive procedure
- Behavioral Health Treatment, for example,
  - Medication dosing changes
  - Medication changes

Phone number where I can be reached during the provision of health services: _____

_____

Authorization Signature - Parent/Legal Guardian

_____ _____

Printed Name - Parent/Legal Guardian Date/Time

_____

Relationship to Patient

_____

Witness - Mission Partner and/or Notary