VERIFICATION OF INFORMED CONSENT FOR GENERAL CARE AND TREATMENT FOR MINOR CHILD

TO THE PARENT: You have the right, as the parent, to be informed about the condition and the recommended surgical, medical, or diagnostic procedure to be used on your child so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in the care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s) for your minor child. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent. If you have any concerns regarding any test or treatment recommended by your child's health care provider, we encourage you to ask questions.

NAME OF CHILD:_____**DATE OF BIRTH:**_____

I, _____ , **certify or affirm that I am the parent, adoptive parent or an individual who has been granted exclusive right and authority over the welfare of the above named child under state law** and voluntarily consent to and authorize Terry Reilly, its staff, physicians, and other practitioners to administer, provide, and perform, such general medical care, tests, routine procedures, counseling, delivery of laboratory results, and other services that are deemed necessary, advisable, or beneficial by the providers to effectively diagnose and treat my child. This includes all routine diagnostic tests and procedures, including x-rays, the administration or injection of pharmaceutical products and medications, and the withdrawal of blood for laboratory examination. STI testing and treatment, and pregnancy testing may be included in routine diagnostic testing if applicable. I understand that no guarantees have been made to me as to the results or effectiveness of such treatment and care for my child's condition.

Excluding a medical emergency or extraordinary circumstances, I understand that no substantial procedure will be performed without providing me with an opportunity to give or refuse informed consent for that specific procedure. In giving my general consent for care and treatment for my minor child, I understand that I retain the right to refuse any particular examination, proposed care, testing, surgery, procedure, treatment, therapy or medication, including HIV testing, and that I have the right to revoke this general consent for care and treatment at any time. My refusal to consent to a recommended procedure will not jeopardize my child's right to receive appropriate medical care.

I voluntarily request Terry Reilly and its medical, dental, nursing, behavioral health, pharmacy and other professional staff or their designees, including learners, as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition for which I have brought my child to seek care and treatment at Terry Reilly. I authorize the dispensing of over the counter and prescription medications by the Terry Reilly Health Services Pharmacy to my child.

HIV testing will be offered as part of the routine laboratory tests recommended. Receipt of Family Planning Services is not a prerequisite to receive any other services offered by Terry Reilly Health Services.

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS VERIFICATION OF **INFORMED CONSENT FOR GENERAL CARE AND TREATMENT FOR MINOR CHILD.** I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS, AND ANY QUESTIONS THAT I HAD HAVE BEEN ANSWERED BY STAFF TO MY SATISFACTION.

_____ _____

Signature Date

_____

Printed Name