



Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

CONSENT TO AND DIRECTION FOR TREATMENT OF MINOR

TO: The Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the doctors, nurses, and members of the medical staffs thereof.

RE: _____, a minor.

Date of Birth _____ Medical Record No. _____

I, (We), being the parent(s) or guardian(s), entitled to the care, custody and control of the aforesaid minor, do hereby authorize, request and direct you and each of you to render such treatment to said minor as in your judgment is advisable.

It is contemplated that the above minor may from time to time appear at your hospitals, clinics, offices and facilities for examination or treatment, or both, unaccompanied by an adult, because of my (our) absence or unavailability.

I, (We), understand that the physicians, nurses or administrators may deem it advisable that a parent or guardian or other authorized adult be present with said minor for the purpose of assisting in the diagnosis or treatment. I, (We), agree to cooperate by being present with said minor at all times possible or when requested.

This consent will be in effect until it is terminated by written notice received by the Physicians of The Permanente Medical Group, Inc. at the Hospital or Medical Office location(s) where the original consent has been filed.

X _____
SIGNATURE

X _____
SPECIFY RELATIONSHIP

X _____
SIGNATURE

X _____
SPECIFY RELATIONSHIP

Dated: _____, 20 _____

NOTE: This form should be completed for each minor in the family and filed with the Chart Room Supervisor at the Kaiser Foundation Hospital or Permanente Clinic where you expect services to be rendered.