IMS
INTEGRATED MEDICAL SERVICES

# Consent for Treatment of a Minor without Parent or Guardian Present

I, _____ authorize and consent to Integrated Medical Services, Inc. (IMS) to medically evaluate and treat my child/children named below when I am not present. This consent includes, but is not limited to:

- complete physician check-up
- hearing, vision, scoliosis, and blood pressure screening
- immunizations
- first aid and emergency care
- prescriptions and treatment for illness

I also understand that it may be necessary to perform diagnostic tests (for example, throat cultures, urine samples or blood tests) in the course of the evaluation.

Please identify any limitations or restriction for which this consent is given. If none are specified, no limitations will be applied.

_____

My child/children may be accompanied by: _____

Relationship to child: _____

I give permission to share any relevant health information with the above named person when they are accompanying my child.

This authorization and consent is valid for the following child/children:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

I hereby indemnify and hold harmless IMS, its officers, agents, employees from any and all liability for acting in reliance on this authorization. I also agree to accept financial responsibility for all care and services delivered pursuant to this authorization.

_____ _____

Parent Signature Date

_____

Phone Number