



PERMISSION TO ACCOMPANY A MINOR

I _____ give permission to _____
(Name of guardian) (Name of adult to be accompanying child)

accompany my child _____ and authorize treatment for my child in Accordance with the office policy of NorthShore Health Centers. This includes bringing the child into the office of NorthShore Health Centers, providing a history of present illness, disclosure of protected health information, witnessing any physical exam completed by the provider, and responsibility for relaying any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be Financially responsible for all co-pays and coinsurance.

Appointments with NorthShore Health Center’s Behavioral Health Consultants will require the parent or guardian to be present at the minor patient’s initial appointment.

This authorization is effective on: _____ and expires _____.
(Today’s date) (Date authorization not valid)

(Signature of Parent/Legal Guardian)

Child’s Name: _____ **Child’s Date of Birth:** _____

Home Phone: _____ **Parent Cell Phone:** _____

Parent Work Phone: _____

Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency? _____

Phone: _____

Comments:

Temporary Guardian Information

Name: _____

Phone: _____

Address:

Health Insurance Information

Insurance Company: _____ Policy Holder: _____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

Child’s Health Information

Current prescribed or over-the-counter medications and dosages:

Allergies, illnesses or other information?
