



### Minor Care Consent Via Phone

Parent's Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Patient's Name & Birthday: \_\_\_\_\_

Person given permission to bring Minor Child to ICO: \_\_\_\_\_

Relationship to Patient or \*Self: \_\_\_\_\_

\*If "Self" 16-17 years old or new patient then fax Authorization/Consent to Treat form, HIPAA, or updated CTT to obtain signature from a guardian/adult before patient is seen (excluding pregnancy or emergency cases).

### Medical Information

Drug allergies: \_\_\_\_\_

Medical History (hospitalization, seizures, surgeries, etc.): \_\_\_\_\_

Current Medication (i.e.-Tylenol, Motrin, Benedryl, etc.): \_\_\_\_\_

CSA Initials : \_\_\_\_\_ Date: \_\_\_\_\_

