

MINOR CONSENT

| For Children Un | der Age 18 |
|-------------------|--|
| I authorize my ch | ild, Date of Birth |
| to be seen on | —————————————————————————————————————— |
| 1. Acco | ompanied to Appointment: |
| | My child may be seen only accompanied by and BCHP personnel. |
| 2. Acco | ompanied in Examination Room: |
| | My child may be seen and treated in the examination room only accompanied by and BCHP personnel. |
| | authorization is valid for the following date or period of time |
| Parent/Guardian | Signature ————— |
| Print Name | |
| Date | |