River Health & Wellness

Tanecia Webster, ANP

Consent to Treat

_____ _____

Childs Name Date of Birth

When I, the undersigned parent or legal guardian of the child listed above, are not present,

I authorize River Health and Wellness who is the primary care office to the child to perform and provide medical care to said child, when such services are recommended and supervised by Tanecia Webster.

I understand that, despite this consent, River Health and Wellness, in its sole discretion, may decide not to act on this consent, and instead require my presence during my child's treatment or care.

I also understand that I am financially responsible for any co-pays and charges not covered by my insurance which are incurred as a result of this consent for treatment and care.

Unless it is revoked sooner in writing, this consent remains effective for 1 year from the signed date.

X _____ _____

Parent or legal guardian signature Date

_____ _____

Name (Print) Phone

_____

Address

Childs known allergies: _____

Other significant health problems: _____

Date of child's most recent tetanus shot: _____

Medications currently being given to the child: _____

☐ No Signature obtained, received verbal consent over the phone from the child's parent/guardian

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