MIDWEST INTEGRATIVE HEALTH LLC

MIH - Consent to Treat a Minor

My name is:

Legal full name of minor child:

Legal full name of minor child:

DOB of minor child:

Address of minor child:

By signing my name below, I am giving my permission to the following organization/provider to treat my minor child:

Midwest Integrative Health, LLC and Jessica Thorman, APRN, FNP-C

Treatment may include, but is not limited to:

• Routine preventative care

• Physical examinations

• Diagnostic tests (e.g., blood tests, X-rays)

• Medical procedures

• Administration of medications

This consent will remain in effect until revoked or until said child turns eighteen (18) years old.

Emergency Contact Information:

Parent Name, Phone number, Address, Email Address

Medical Information

Please list any known allergies, medical conditions, or medications taken (daily and as needed)

Signature and Authorization

I confirm that I am the parent or legal guardian of the above-named child and have the legal authority to grant this consent.

Date