BRIGHAM AND WOMEN'S HOSPITAL

OCCUPATIONAL HEALTH SERVICES
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# Consent to Evaluate and Treat a Minor

I am the parent or legal guardian of _____ and as such I authorize the Partners Occupational Health Service to provide medical care to my child for the evaluation and treatment of minor injuries. I understand this care may include diagnostic examinations (including radiological and laboratory testing), physical or occupational therapy, and/or administration or provision of medications as indicated for my child's medical condition.

By signing this form I acknowledge that I have read and understand this consent and that any questions I had were answered by a Nurse Practitioner in the Partners Occupational Health Service.

_____
PRINT YOUR NAME

_____ Date: / /
PARENTAL SIGNATURE

My consent is effective from / / to / /

Please provide contact information so we can keep in touch with you and update you regarding your child:

Home Phone ( ) -

Cell Phone ( ) -

Business Phone ( ) -

Email Address: