Deaconess Clinic, Inc.
Consent of Medical Treatment for Minors

I, ______________________ as parent or guardian of ______________________, give written permission for medical services to be provided in my absence.

My signature below means I understand and agree to the statements below:

• Dr. Riedford will be in charge of the care provided. He may have help from other doctors or clinical staff.

• Exams or other procedures may be performed to diagnose or treat the condition.

• Medical care is not an exact science. The doctors and staff providing care will use their best judgement, but there is no guarantee that the exam or treatments provided will have a good result.

• I understand this consent allows for all services which do not require an additional separate consent. I have been given the opportunity to ask questions and am satisfied with the answers I have received.

• I have read this consent form or have had it read to me. I understand the information in the form and have been given a copy to keep.

• I understand this completed form will be kept as part of the medical record.

______________________________  ______________________________
Patient or Patient Representative Signature  Date/Time

______________________________  ______________________________
Representative’s relationship to patient  Witness signature
IMMUNIZATION CONSENT FORM

I have received and read the information pamphlets and I have had the chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccination(s) marked below and have requested the vaccine(s) listed be given to me or the person named above for whom I am authorized to make this request.

Signature of Patient or Legal Guardian

Date

Expiration Date ________________

☐ DTP
☐ DTaP
☐ DT
☐ Td
☐ Hepatitis A
☐ Hepatitis B
☐ Hib
☐ Influenza
☐ IPV (inactivated polio)
☐ Prevnar (Pneumococcal Conjugate)
☐ Pneumovax (PPV)
☐ MMR
☐ Varicella
☐ Pediarix
☐ Comvax
☐ Meningococcal
☐ Boostrix
☐ Adacel
☐ Synagis
☐ Pentacel
☐ Other(s)

☐ Rota Teq
☐ ProQuad
☐ HPV
☐ Zostavax

Send completed form to Medical Records for scanning.