Consent for Care: MINOR

I,_____, the undersigned, hereby give Wahiawā Health Center to examine my (son/daughter/ward):

Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth

to make such tests as are necessary for his/her diagnosis and care, and to give such treatment as the Wahiawā Health Center physicians deem necessary. This includes diagnosis and care at the Center clinic, at laboratories, X-ray facilities, clinics, emergency rooms and offices of specialists, and psychological tests.

I understand that for major surgery or other major procedures, special explanations will be made to me and special permission will be requested for me, unless the emergency is too great to wait to contact me.

This consent which I am signing is for the ongoing health care of my (son/daughter/ward) until I withdraw him/hear from the Center. I understand that it includes consent for general tests, tuberculin tests, applications to skin or mucous membranes, examination of mouth, genitals, rectum, and ears, repair of small cuts, and all other ordinary medical office procedures.

I am not hereby consenting to any experimental procedures nor to tests for research or scientific study.

My photograph and that of my child may be used for medical records and for publicizing the Wahiawā Health Center.

I certify that I have read (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed. Exceptions:

_____

_____

_____

_____ _____

Parent/Legal Guardian Signature Date