grand itasca® Clinic & Hospital | *Part of Fairview Health Services*

**Minor Consent Form**

_____DOB_____

*(PRINT Patient Name)*

*Date*_____

1. _____(*PRINT name of person you give permission to)*

2._____(*PRINT name of person you give permission to)*

3._____(*PRINT name of person you give permission to)*

has my permission to consent to evaluation and treatment of the above minor patient at Grand Itasca Clinic & Hospital.

Please check the box, and initial one of the following so that this consent remains valid for the requested time frame:

- ☐ _____This consent is valid for the following dates of service: _____
  *(Initial)*
- ☐ _____This consent will not expire unless I revoke it in writing.
  *(Initial)*

**Signature of Parent/Legal Guardian:**

_____

*(Signature)* *(Date)*

_____

*(Printed Name of Parent/Legal Guardian)* *(Relationship to Patient)*