CONSENT FOR FULL CIRCLE NUTRITION TO TREAT MINOR IN THE ABSCENCE OF PARENT and/or LEGAL GUARDIAN AND ALLOW ALTERNATIVE ADULT

I, _____, parent or guardian of _____

a minor, do hereby authorize the following adults to bring my minor child to his or her appointment. I am unable to attend becuase: _____

a. _____ Relationship:_____

b. _____ Relationship:_____

c. Self, ☐ if 16 years of age or older and if minor child controls more than 50% of food choices or themselves (purchase and preparation, whether home cooked or eaten out.)

This authorization allow the aforementioned adult to sit in on my minor child's appointment. I understand PHI may be discussed.

This authorization is effective from _____/_____/_____ to _____/_____/_____, unless sooner revoked in writing delivered to said agent(s).

_____/_____/_____ _____

Date Signature of parent, guardian or other legal representative

PATIENT INFORMATION FOR MINOR LISTED ABOVE

Patient's Name:_____ Date of Birth: _____/_____/_____
Home Address:_____
_____
Current Medication(s):_____
Allergies:_____
Parent or Guardian Name(s): (1)_____
Relationship_____
(2)_____
Relationship_____
Primary Insurance Company:_____
Person Who Carries This Insurance:_____
Address (if different from above):_____
_____
Insurance ID Number:_____Group Number:_____
Customer Service Number on back of card_____