CONSENT FOR MINOR TO RECEIVE CLINIC SERVICES

PLEASE PRINT ALL INFORMATION REQUESTED BELOW

Tazewell County Health Department requires written or verbal consent from a parent or legal guardian to provide medical services. A minor (child under the age of 18) may not consent for their own medical services unless they are emancipated by a court, pregnant, married, minor-parents, or a "minor seeking primary care" with verification of status in writing by a qualified adult under the Illinois Consent by Minors Act.

PARENT/LEGAL GUARDIAN FULL NAME: _____

RELATIONSHIP TO MINOR/CHILD LISTED BELOW: _____

CHILD'S LEGAL NAME: _____

CHILD'S DATE OF BIRTH: _____

APPOINTMENT DATE: _____

As the parent or legal guardian of the child listed above, I give my consent for my child to receive clinic services at the Tazewell County Health Department clinic. ***This consent is valid only for the date listed above.***

I understand that my child must be accompanied by a responsible person aged 18 or over. The person who will accompany my child has full permission to attend the visit, and sign for consent for services.

Name of accompanying responsible adult: _____

Phone number where I can be reached during the appointment: _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____

TODAY'S DATE: _____

TAZEWELL COUNTY HEALTH DEPARTMENT
21306 ILLINOIS ROUTE 9
TREMONT, IL 309-925-5511

TCHD Staff ONLY: Verbal Consent Validation

TCHD Employee name: _____

Date/Time consent received: _____