Consent to Treat – Non-Parent/Guardian to Accompany Patient

This authorization gives below named person(s) permission to bring your child(ren) in, speak to the doctor, authorize the child for treatment, vaccinations, medications, certain procedures and to make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to vybe urgent care and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider.

I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE' BELOW)

_____ _____

Name of Person (allowed to bring child) Relationship

_____ _____

Name of Person (allowed to bring child) Relationship

_____ Printed Name of Parent

_____ Signature of Parent

_ _____ Date

*This form must be accompanied by a copy of a photo ID of the parent or guardian.