



Augusta Family Practice · 1306 State Street · Augusta, KS 67010 · (316) 775-9191

El Dorado Sports & Family Medicine · 700 W. Central, Ste 200 · El Dorado, KS 67042 · (316) 320-9191

Rausch Clinic · 619 S. Hwy 77 · Douglass, KS 67039 · (316) 747-2300

CONSENT FOR TREATMENT OF MINOR

I, _____, being the parent or legal guardian of _____, give my consent for medical treatment of this minor in the event that such treatment becomes necessary. I grant my permission for treatment by Dr. Michael A. Rausch and the physician's assistants, nurse practitioners and designees, including such clinic personnel as the physician may deem necessary. I understand that clinic personnel will make reasonable attempts to contact me in an emergency situation before initiating treatment. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. The minor named in this consent form may receive all treatment provided according to generally accepted standards of medical practice with the following limitations (if none, write "NONE"): _____.

My consent is effective for the following time period: FROM: _____ TO: _____

Printed Name of Parent or Legal Guardian

Street Address, City, State, Zip of Parent or Legal Guardian

Home Phone #

Work Phone #

Cell Phone #

Emergency #

I designate the following persons to bring my child in for care in your clinic:

Name

Phone

Relationship

Name

Phone

Relationship

Name

Phone

Relationship

Signature of Parent or Legal Guardian

Date