Verbal Consent to Treat Minor for SBHC Visit

School: _____ Grade: _____ Date: _____

Patient Name: _____ DOB: _____

Parent/Guardian: _____ Relationship: _____

Phone Number: _____ Work: _____ Cell: _____

Address: _____

Insurance (if needed): _____ Address: _____

ID#: _____ Group#: _____

Policy Holder Name: _____ DOB: _____

Chief complaint: _____

Would you like for us to see your child today? ☐ Yes ☐ Yes OTC only ☐ No

Drug Allergies: ☐ No ☐ Yes _____

Health Problems: ☐ No ☐ Yes _____

Medications: ☐ No ☐ Yes _____

Regular PCP: ☐ No ☐ Yes _____

Pharmacy: _____

I have spoken with the guardian of this minor patient and they have given verbal permission for said patient to be treated at the Brandon School-Based Health Services.

Guardian understands that this permission is for today's visit only and may not be transferred to any other date than the one above which is stated.

The guardian also verbally expressed understanding that if proof of insurance is not presented at the time of visit, the guardian will be billed (if patient is being evaluated and treated by mid-level provider at SBHC).

_____ _____

Staff Signature: Date:

_____ _____

Secondary Signature: Date:

BRANDON SCHOOL-BASED HEALTH SERVICES

BARBOUR COMMUNITY HEALTH

99 Horseshoe Drive | Philippi, WV 26416

(304) 457-4000

www.barbourhealth.org