



# Krohn Clinic LTD.

*A Primary Health Care Community*

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## CONSENT TO TREAT MINOR FORM

I, \_\_\_\_\_, the parent/guardian  
of \_\_\_\_\_, grant permission for  
my above named child to be treated at the Krohn Clinic.

This consent covers the date of \_\_\_\_\_ (month/day/year). I do hereby  
indemnify and hold harmless the physicians and other healthcare workers who act in  
reliance with this authorization.

Date: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

Time: \_\_\_\_\_ Witness: \_\_\_\_\_

Verbal Consent  Second Witness: \_\_\_\_\_

### **Additional Information:**

Parent/Guardian can be located at the following phone number/address:

Any allergies and/or medical conditions of child:

### Insurance Information:

Insurance: \_\_\_\_\_ Insurance Co. Phone Number \_\_\_\_\_

Group Number: \_\_\_\_\_ Subscriber Number: \_\_\_\_\_

Child's Birth Date: \_\_\_\_\_  
(Please send a copy of insurance card, if available)

Krohn Clinic Label