Patient Name

DOB:

MR #

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

INFORMED CONSENT FOR TREATMENT OF MINORS AND ADULT WARDS

Index to Consent – Treatment/Procedures

Date: _____

I allow the physicians and other treatment providers assigned to give medical care to _____, a minor child/ward for whom I have legal custody or am the guardian. I give my consent now because my child/ward may arrive alone, or with someone involved in their care but who is not the parent or guardian. I affirm that I have the power to give this consent.

List the name(s) of people below that I give permission to accompany the child/ward during their visit:

_____

_____

☐ **Informed Consent for Medical Care (Does not include shots)**

☐ **Informed Consent for Shots, Vaccines, Serums, Toxoids, Immunotherapy**

I understand there are risks with shots, as with anything put into the body. These risks may include a rash, hives, trouble breathing, shock, paralysis, brain damage or death. If my child/ward is to get a vaccine(s), I agree that I have received a copy of the Vaccine Information Statement (VIS) for the vaccine(s) that will be given.

I have received information about:

- The treatment (what will be done and why),
- The benefits and risks of the medical care,
- The risks of no treatment, and
- Other treatment options

I have had the chance to ask questions and have them answered to my liking. I have the information I need to give my informed consent to treat my minor child/ward.

PLEASE NOTE: *In case of an emergency and the patient presents alone, the treatment providers will give all care they feel is needed. This includes emergency care, transport to a hospital, and other medical, surgical or diagnostic procedures. Please write in if you have a preferred hospital:*

_____

End date: This consent ends one year from the date signed unless stated here: _____
(mm/dd/yyyy)

The date may not be past the patient's 18th birthday, unless the patient is incompetent, and guardianship will continue after their 18th birthday.

Verbal consent ☐ Yes ☐ No
If yes, reason for verbal consent:
☐ Phone consent
☐ Other _____

AUTHORIZING SIGNATURES:

Signature of Representative _____ Date: _____ Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

- Patient is: ☐ Minor ☐ Incompetent / Incapacitated
- Legal Authority: ☐ Legal Guardian ☐ Parent of Minor
  ☐ Health Care Agent ☐ Other _____

*Provider Signature: _____ Print *Provider Name: _____

Date: _____ Time: _____ Pager# _____

_____ _____
Interpreter or Reader Signature (if applicable) Witness Signature**

_____ _____
Print Interpreter or Reader Name Print Witness Name

_____ _____
Date Time Date Time

* Provider can be Physician or Advance Practice Provider performing the procedure.
** Only required if patient signature not obtained by provider or when telephone consent obtained.