CONSENT FOR TREATMENT OF UNACCOMPANIED MINOR

Privacy Act Statement: This document may contain information covered under the Privacy Act. 5 USC 552(a), and/ or the health Insurance Portability and Accountability Act (PL104-191)and its various implementing regulations and must be protected in accordance with those provisions

A parent or legal guardian must provide consent for a child younger than 18 years of age for all medical and/or surgical treatment provided by US Naval Hospital (NAVHOSP) Yokosuka and Branch Health Clinics (BHC). This form will be completed if your child (14 years or older) will be coming for a visit, treatment, or procedure, without a parent or legal guardian. This consent is valid for the specified purpose and time period indicated below only, has a maximum duration o f one year from date signed, and may be revoked by the parent/legal guardian at any time in person, in writing, or via telephone.

Minor Patient Name _____
Address _____
Date of Birth _____ Phone _____

Clinical Location Mass Vaccination site aboard CFAY
Purpose/Indication receipt/administration of annual influenza vaccine injection

Time Period **C**onsent is valid for the time period of: 01 OCT 2024 to 01 JAN 2024.
(Not to exceed one year) at which time a new consent form would be required.

I, _____, the legal guardian of the above named child, authorize and give
(Parent/Legal Guardian)
consent for my child to go independently to appointments at NAVHOSP Yokosuka and/or related BHC and consent to treatment only related to the above stated purpose/indications in my absence. I understand such services may include examination, medical treatment, x-ray (chest and/or extremities only), laboratory, immunizations, picking up of own medications, and other medical services performed or prescribed. Minor surgical procedures require a procedural consent form to be completed additionally. This consent does not apply to initial surgical sub-specialty visits. I recognize that by signing this form, I am, as the legal guardian, still responsible for any and all medical expenses incurred at the visit.

I understand that this minor will be given medical information in lay terms to ensure to the best degree possible that informed consent was obtained for any procedures or treatment.

I understand that, in certain circumstances, the healthcare provider of NAVHOSP Yokosuka and/or related BHC may require that a parents or other authorized adult be present with the minor to assist in the diagnosis or treatment process. I agree to cooperate by being present at all times possible when requested. I aware that I may request to speak to the provider after the visit by contacting the clinic directly.

Child must be 14 year of age or older. This form will be uploaded to child's electronic medical record.
Consent was completed (circle one): IN PERSON IN CLINIC VIA PHONE/FAX/EMAIL

Relation to patient (circle one): PARENT LEGAL GUARDIAN AUTHORIZED THIRD PARTY

_____	_____	_____
(Printed name of Parent or Legal Guardian)	(Parent or Legal Guardian Signature)	(Date)
_____	_____	_____
(Printed name of Staff member/Witness)	(Staff member/Witness Signature)	(Date)
_____	_____	_____
(Printed name of Staff member/Witness)	(Staff member/Witness Signature)	(Date)

Please reference NAVHOSPYOKO Instructions 6320.16 and 6320.14 for further information.