**The Door – A Center Of Alternatives, Inc.**
**Adolescent Health Center**

## HEALTH CARE SERVICES
## CAREGIVER CONSENT FORM

**Child's Name (First & Last Name): ______________________________ Date of Birth: _____________________**

Any drug allergies? No ☐ Yes ☐ If yes, please specify: _____________________________________________

Current medication? No ☐ Yes ☐ If yes, please specify: _____________________________________________

Permission is granted for my child to receive health care services at The Door - Adolescent Health Center for routine medical services, for treatment of illness, and/or in the event of an emergency.

**Services may include:**

- **Primary Care**
  - ☐ A complete physical exam, including sports, school or camp physicals, basic laboratory testing, diagnostic testing, first aid, prescription medication, vaccinations, sick visit, treatment for injury, psychosocial assessment, mental health services, nutritional counseling, dermatology, and outside referrals as needed.

- **Dental Care**
  - ☐ An oral examination, including general care and cleaning, digital X-rays, fillings, fluoride treatments, sealants, oral health education and instructions, and referrals for follow-up dental care as needed.

- **Eye Care**
  - ☐ A comprehensive eye exam, including diagnosis and treatment, binocular assessment, glaucoma and cataract evaluation, evaluation of eye health to assess for infection or disease, and referrals as needed.
  - ☐ Dilation exam - A dilation exam is a procedure in which drops are instilled in each eye to increase the pupil size so that the inside of the eye may be inspected better by the doctor. This procedure is recommended by the doctor in order to perform the most thorough eye health examination possible.

By signing below, I certify that I am the legal parent or caregiver of the child identified above and I am acting within my authority in signing this consent form.

| ______________________________ | ______________________________ | ______________________________ |
|---|---|---|
| **Parent or Caregiver Name (PRINT)** | **Parent or Caregiver Signature** | **Date** |
| ______________________________ | ______________________________ | ______________________________ |
| **Email Address** | **Home Phone Number** | **Mobile Phone Number** |

**Back-up Emergency Contact Info (to be completed by Parent or Caregiver):**

| ______________________________ | ______________________________ | ______________________________ |
|---|---|---|
| **Print Name** | **Relationship** | **Contact Phone Number** |