**FAMILY INFORMATION SLIP**

One form may be used for the entire family provided that the responsible party is the same for each child.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDREN’S:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **LAST NAME** | **FIRST NAME** | **MIDDLE NAME** | **SEX** | **DATE OF BIRTH** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

FATHER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MOTHER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As a parent/legal guardian, I understand I must give permission for my child to receive medical treatment. If at all possible, I will come with my child for every appointment at Carolina Urology Associates.

If I cannot come with my child, I agree to let \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and/or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name and Relationship) (Name and Relationship)

give permission for any treatment.

(Examples of persons to name here may be stepparent, grandparent, sitter, etc.)

If my child comes with anyone other than myself or the persons listed above, I agree to send with them a written note, with my signature, giving permission for treatment.

**\*\*Child must be 18 years of age to be treated without a parent/guardian present. \*\***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date Responsible Party Signature Date