Pueblo Community Health Center
Your Health. Our Mission.

Supplemental Information Form - Minors

PLEASE PRINT (**ONE** form per minor)

Date: _____

Patient Information

Legal Name: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____

Parent Information

1st Parent Name/ Guardian: Last _____ First _____M.I. _____

Birth Date: ____/____/_____ Relationship to Patient: _____

Phone(s): Day: (____)_____-_____ Cell: (____)_____-_____

Secondary Contact Number: (____)_____-_____

2nd Parent Name/ Guardian: Last _____ First _____ M.I. _____

Birth Date: ____/____/_____ Relationship to Patient: _____

Phone(s): Day: (____)_____-_____ Cell: (____)_____-_____

Secondary Contact Number: (____)_____-_____

Delegated Consent to Treat

Please complete this section if you to appoint a person(s) to bring minor in for appointment.

I (We) _____ and _____
Parent/Guardian Name Parent/Guardian Name

hereby state that I/we, the parent(s) or legal guardian(s) of _____, a minor, born on _____
Minor child's name DOB

authorize _____ , _____, _____, (Assigned Person(s) Name), an adult, to consent to any necessary examination, medical diagnosis or treatment to be rendered to the above named minor under the general or special supervision and on the advice of any provider licensed to practice at Pueblo Community Health Center.

Signature of Parent/Guardian _____ Date_____

Authorized Use Only

Staff initials: _____ Dept: _____

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