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## Consent to Routine Medical Care/Treatment for Minors

**Parent/Guardian Consent:**

I, \_\_\_\_\_ give permission for my minor child \_\_\_\_\_  
Full Name of Parent or Guardian Full Name of Child

to receive routine medical treatment at Phillips Medical Group, P.C. under the supervision of any and all of the following named adults in my absence. I understand that a government-issued picture identification will be required of the adult supervising the child at the time of service.

Last Name	First Name	Relationship to Child
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____		_____
<small>Signature of Parent or Guardian</small>		<small>Date</small>
_____		_____
<small>Witness</small>		<small>Date</small>

**Parent/Guardian Consent – ONLY IF PT IS A MINOR 14 YEARS OF AGE OR OLDER**

I, \_\_\_\_\_, attest that my minor child, \_\_\_\_\_  
Full Name of Parent or Guardian Full Name of Child

is fourteen years of age or older. I give permission for my minor child, named above, to receive routine medical treatment at Phillips Medical Group, P.C. in my absence.

_____	_____
<small>Signature of Parent or Guardian</small>	<small>Date</small>
_____	_____
<small>Witness</small>	<small>Date</small>

*If the medical care provider believes that delay in rendering emergency care to the minor child named above will, to a reasonable degree of medical certainty, result in a serious threat to life of the minor or a serious worsening of the minor's medical condition, such treatment shall be commenced only after reasonable effort is made to notify the minor's parent(s) or guardian(s), if known or readily ascertainable. [TCA 63-6-222(a) (b)].*