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: _____

Permission is granted for my child to receive health care services provided by a licensed clinician and support staff at the Adolescent Health Center of The Door.

Services may include:

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

- **Dental Care**
  - A oral examination, general care and cleaning, digital X-ray, fillings, and Fluoride treatments, sealants, oral health education and instructions, and referrals for follow-up dental procedures.

- **Eye Care**
  - Comprehensive eye care, diagnosis and treatment, binocular assessment, glaucoma and cataract evaluation, and evaluation of eye health to assess for infection or disease.
  - 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 through eye health examination possible.

I understand that all information will be kept confidential, or if a consent is signed by me which allows the health center to release my child's records. I have read and understand the above information. This consent will remain in effect unless and until I cancel it in writing.

_____	_____	_____
Caregiver Name	**Caregiver Signature**	**Date**
_____	_____	_____
Email Address	**Home Phone**	**Mobile Phone**

<u>Back-up Emergency Contact Info:</u>

_____	_____	_____
Name	**Relationship**	**Contact Number**