BLANKET CONSENT FOR HEALTH CARE SERVICES OF A MINOR CHILD

This form must be completed and signed by a parent of the minor child, unless the minor is emancipated. "Parent" means the biological or adoptive parent of the minor or an individual who has been granted the exclusive right and authority over the welfare of the minor under state law. A minor is emancipated if they are married, serving in the active military, subject to a court order declaring such minor to be emancipated, or they have rejected the parent-child relationship, are living on their own, and are self-supporting.

BLANKET CONSENT

I, the undersigned parent, hereby grant blanket consent to the provision of health care services

to my child, ___________________________________, by Full Circle Health's care team and affiliated healthcare
Child's Name

providers at Full Circle Health. I understand that this blanket consent for health care services allows for the diagnosis, screening, examination, prevention, treatment, cure, care, and relief of my child for any physical or mental condition, illness, injury, defect, or disease, including, but not limited to:

- Primary care services
- Routine vaccinations
- Contraception *(including birth control)*
- HPV vaccination
- Pregnancy treatment
- Prenatal care and delivery
- Behavioral and mental health screening and treatment
- Outpatient substance abuse screening and treatment
- HIV testing and treatment
- Sexually Transmitted disease or infection testing and treatment

Understanding of Risks and Benefits

I understand that I have a right to be informed about my child's condition and the recommended treatment or procedure to be used so that I may make the decision whether or not my child should undergo any suggested treatment or procedure after knowing the risks and benefits involved. Excluding emergency situations, when furnishing the Health Care Service(s) is necessary to prevent death or imminent, irreparable physical injury to the Minor Child. I understand that no substantial procedure will be performed without being provided with an opportunity to give or refuse informed consent for that specific procedure. I agree to have my child speak with a provider alone for services as outlined above if they choose to do so.

Duration and Revocation of Consent

I understand that I may revoke this consent at any time by providing written notice to Full Circle Health. However, I acknowledge that revocation of consent may not be effective in emergency situations where my child's life or health is at risk and does not apply to any uses or disclosures made by Full Circle Health before receipt of this completed revocation form or for uses or disclosures that are allowed or required by law. Unless revoked earlier, I understand that this blanket consent will be valid for a period of one (1) year from the date of my signature below.

By signing this form, I acknowledge that:

- I have read and understand the purpose of providing parental consent for today and all future visits and/or treatment of my child.
- I understand that I have a right to terminate treatment at any time.
- I understand that I have the right to revoke this consent by providing written notice to Full Circle Health.
- I understand this consent is valid for one (1) year from the date of my signature.

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Child's Name (Printed) Child's Date of Birth

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Parent's Name (Printed) Parent's Signature Today's Date