YO SAN UNIVERSITY BLOUNT COMMUNITY CLINIC

AUTHORIZATION TO TREAT A MINOR

I, the undersigned, parent/legal guardian of:

Name of Minor/Patient: _____

Date of Birth (mm/dd/yyyy): _____

Hereby grant my authorization and consent for a supervised intern, clinical faculty, or licensed acupuncturist from the Yo San University Clinic to administer Traditional Chinese Medicine (TCM) therapeutic modalities such as acupuncture, electric acupuncture, herbal supplements, and/or Tuina/Asian bodywork to the aforementioned Minor, as is medically indicated.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or care being rendered.

I further understand that the intern/practitioner attending to my child will take all necessary safety precautions in the care of the aforementioned Minor.

This authorization shall remain effective until _____ (mm/dd/yyyy), unless sooner revoked in writing delivered to Yo San University Clinic.

Name of parent/guardian: _____
(please print)

Signature of parent/guardian: _____

Relationship to Minor/Patient: ☐Parent ☐Legal guardian
(please check one):

Date:_____