

Statement of the statutory representative of a minor

Details of the minor patient's representative

First name and surname

Type and number of identity document

Residence address

Street

House number

Apartment number

Post code

City

Relationship with the minor

☐

father

☐

mother

Telephone number in case of urgent contact

I declare that I consent to the performance of the following low risk medical services **without my presence:**

☐

taking medical history and performing medical examination,

☐

performing non-invasive additional tests (e.g. blood pressure measurement, ECG, X-ray, urine test, transabdominal ultrasound),

☐

blood collection for laboratory tests,

☐

drug administration on demand in the form of a tablet or injection,

☐

issuing a prescription for prescribed medications,

☐

issuing a medical certificate,

☐

performing rehabilitation treatments,

☐

possibly other specific medical services:

and/or I indicate that I do not consent to specific medical services (please enter if any):

To be performed to the minor under my care:

First name and surname of the minor

Personal Id No / Date of birth

☐

The consent is one-time – please indicate the date of the appointment:

Date of the appt.

☐

The consent is general – valid until revoked by the statutory representative

Date and signature of the legal representative submitting the declaration

Signature of the person accepting the declaration (POLMED employee)