*Jody L. Kelly, M.D. & Associates*
*2901 N. Knoxville Avenue*
*Peoria, IL 61603*

*Jody L. Kelly, M.D.*
*Michele M. Pepperell, M.D.*
*Sue Sphar, C.N.M.*

# Parental consent for minor to obtain health services

*Legal guardian must sign before being seen at first appointment. If parent/guardian is unable to accompany patient, a copy of their photo identification should be sent with patient at time of service.*

I, ________________________________________, give my consent for

________________________________________ D.O.B. ____________________

to receive health services under the direction of ***Jody L. Kelly, M..D. & Associates*** .

This grant of consent shall begin on ________________________________ and

shall remain effective until written notice is received.

**Please indicate the services consented for:**

☐ Assessment, diagnosis and treatment of illness

☐ Routine gynecologic examinations

☐ Immunizations

☐ Diagnostic testing including sonograms, blood work, and other recommended tests

☐ Recommended procedures

☐ Administration of Medication

☐ Other ________________________________________

Phone number where I can be reached during the provision of health services:

________________________________________

________________________________________ ____________ ________
**Signature of parent or legal guardian** **Relationship** **Date**

________________________________________ ____________________
**Witness** **Date**