

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