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Osteopathic Manual Medicine (OMM)
Informed Consent – Agave Pediatrics

Patient's Name: _____ Patient's Date of Birth: _____

Parent/Legal Guardian/Legal Caregiver Name: _____

I certify that I, _____, am the parent/legal guardian/legal caregiver of the patient and

have the legal authority to answer these questions and to consent to treatment of my child: _____.

I understand that the Osteopathic Manual Medicine (OMM) physician is providing treatment within the scope of their OMM practice. I understand that it is my responsibility to continue to take my child for appropriate visits to their primary care provider for growth checks, review of milestones, education regarding vaccinations, and regular medical care.

I hereby consent to the OMM physician treating my child. I understand that this treatment can involve them placing their hands on my child's body, which may include areas like the tailbone (sacrum), pelvis, pelvic floor, pubic bones, chest, head, neck, within the mouth, and more. I understand that the OMM physician may ask that certain articles of clothing be removed (such as a shirt or pants) in order to help with the examination and treatment. The OMM physician will make every attempt to maintain modesty and to keep the child comfortable. If either myself or my child is uncomfortable with treating one of these body regions or with having these articles of clothing removed, I will make the OMM physician aware immediately. The treatment can be adjusted or stopped to keep the child comfortable.

I understand that the OMM physician may also have a fellow physician, resident, or student accompanying them in order to learn OMM. I hereby give consent to allow another physician, resident, or student to help with providing OMM treatment in conjunction with and under the supervision of the OMM physician. If either myself or my child are uncomfortable with this, I will make the OMM physician aware immediately.

I understand that it is my responsibility as the parent/guardian to provide a full history and any pertinent medical information. A full history would include any information regarding abuse history or motor vehicle accidents. I understand that a complete history is critical in order for my physician and medical care team to make fully informed medical decisions. I understand it is my responsibility to keep the OMM physician up-to-date regarding any health changes.

I understand that if my child should hit/kick/bite/or otherwise injure the OMM physician, the OMM physician reserves the right to end the treatment at their discretion in the interest of personal safety.

I understand that there is no guarantee an OMM treatment will have a specific result. Each patient is different, therefore each patient response to treatment can be different as well.

I understand that with an OMM treatment there can be side effects, which are usually mild in nature. I have had the opportunity to be educated regarding these side effects and to ask questions.

I have had the opportunity to discuss my questions, and understand that I have the right to continue to discuss any questions or concerns I have regarding this consent form and regarding treatment for my child. The information I have provided is true and complete to the best of my knowledge. I have read this consent form and understand this form.

Printed Name Parent/Legal Guardian: _____ Date: _____

Signature Parent/Legal Guardian: _____