AUTHORIZATION FOR MINOR CHILD TO SEEK LIMITED EXAMINATION AND TREATMENT WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT

Name of Child:	
Date of Birth:	
Parent(s) Name(s):	
Legal Guardian:	
Relationship to Child:	
Parent/Guardian Telephone # :	
Address of Child:	
Address of Parent or Legal Guardian:	
Emergency Contact #1 Name & Tel #s:	
Emergency Contact #2 Name & Tel #s:	
Pediatrician Name & Tel #:	
Family Physician Name & Tel #:	
Dentist & Tel #:	
Medications:	1. 2. 3.
Drug Allergies:	1. 2. 3.
Other Allergies:	1. 2.
Medical Problems:	1. 2. 3.
Past Surgeries:	1. 2. 3.
Date of Last Tetanus Shot:	
Insurance Information: • Carrier • Policy # • Group # • Member ID #	
Adult Person to Whom Parent/Legal Guardian authorizes to consent to treat: • Relationship to Child • Tel # • Address	
Physician and office/clinic authorized to rely upon this Consent:	

(I)/(We), the undersigned, parent(s)/person having legal custody/legal guardianship and the legal right to consent to _____, a minor, who is at least 16 years old, to seek healthcare treatment for:

- Some routine, preventative, and basic health care (i.e., school or sports physical examination).
- Follow-up care for an illness/injury that we previously brought our Child for initial treatment (i.e., re-check for an ear infection, strep throat or wound, removal of stitches, recheck of injury).
- Follow-up care for a chronic illness that requires frequent re-examination and follow-up, including:
  _____
- The following immunizations: _____

(I)/(We) acknowledge that have received information on all listed immunizations, including an explanation of risks of such immunizations and the general nature of risks involved.

- Other (specify): _____

(I)/(We) understand that this consent does not extend to any procedure or anesthetic, or

(I)/(We) authorize Dr. _____ and affiliated physicians and practitioners working in the same clinic/office to rely upon this Authorization.

(I)/(We) understand that the physician/practitioners who rely upon this Authorization are not required to perform medical treatment/services/care if they determine my presence is necessary or appropriate, and it is not an emergency. This Authorization does not require a physician/practitioner to treat the above named child.

This authorization shall remain effective until _____, 20___, unless sooner revoked in writing delivered to said agent(s) and the treating physician.

(I)/(We) acknowledge that I am/we are responsible for all charges in connection with care and treatment rendered to the Child during this period, and agree to guarantee payment for services.

Name:	Signature:
Relationship to Child:	Date:

Name:	Signature:
Relationship to Child:	Date:

Witness Signature:	Printed Name
Date:	