Medical Treatment Authorization

Minor's Name: ______________________________ DOB: ____________________

I am aware that my child may require treatment when I am not able to be present. In my absence, I give permission to ____________________________________
(Individual name and relationship to patient)

my permission to authorize medical treatment of my child, ______________________.

-or-

In my absence, I give permission to ____________________________________
(Physician)

To examine and provide treatment to my child, ______________________________.

In addition, the physician has my permission to refer my child's emergent care to the appropriate service physician to provide optimal care for the check ups with immunizations, treatment of illness or injury.

Beginning Date: ____________________ and End Date: ______________________

______________________________ ____________________ ______________
(Parent/ Legal Representative Signature) (Relationship to Patient) (Date)

____
(Print Legal/ Representative Name)

______________________________ ______________
(Witness to Signature) (Date)