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AUTHORIZATION TO TREAT MINOR PATIENT IN ABSENCE OF PARENT/GUARDIAN

I, _____, the parent or legal guardian of:

_____ DOB _____ _____ DOB _____

_____ DOB _____ _____ DOB _____

_____ DOB _____ _____ DOB _____

Hereby authorize:

_____ Relationship to patient _____
(Name of person bringing child to office)
Phone number _____

_____ Relationship to patient _____
(Name of person bringing child to office)
Phone number _____

_____ Relationship to patient _____
(Name of person bringing child to office)
Phone number _____

to accompany my above-named child(ren) to office visits with the physicians at Pediatric Care Corner and consent to the examination and/or treatment of my child(ren) during office visits. This authorization includes the administration of necessary medication as well as any recommended immunizations.

This authorization:

☐ Is effective from _____ to _____

☐ Is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time in writing to Pediatric Care Corner.

_____ _____
Signature of Parent/Guardian Signature of Witness

_____ _____
Date Date