Lakeland Medical Associates

Providing Care for the Entire Family Since 1995

Authorization for Medical Treament of Minors

I, being the parent or legal guardian of the above named minor, do hereby **appoint the following person(s) to act in my behalf** in authorizing unexpected medical care or hospitalization for my minor child **during the period of my absence.**

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

This authorization is valid until the earlier occurrence of:
1.) the individual (minor) reaches age of majority
2.) permission is withdrawn by the parent/guardian
3.) or by the following specific date (optional): Month: ____Day: ____ Year: _____

This document shall be presented to a physician or appropriate representative at such time as unexpected medical care may be required.

Parent/Guardian Signature: _____ **Date:** _____
Parent/Guardian Name: _____
Relationship to Minor: _____