



AUTHORIZATION TO TREAT MINOR WHEN GUARDIAN NOT PRESENT

Patient's Name: _____ Date of Birth: _____

We must have permission from a child's parent or guardian before providing medical services when the child (under age 18 years) is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc., please fill out the following information for us to include with your child's records.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

For patients 16 years and older ONLY:

Yes____No____ The patient listed above may present and be treated unaccompanied by an adult.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Print Name: _____

Date_____