The Kidz Docs
Pediatric &
Adolescent Medicine

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Authorization for Treatment and/or Immunization of Minors
In Absence of Parent or Guardian

Today's Date: _____

Patients' Name: _____ Date of Birth: _____

My child is 16 years of age (or older). I hereby give The Kidz Docs authorization to treat my child in my absence for:

Please circle all applicable visit types

Sick Visits

Well checkups

Vaccine administration

PPD (tuberculosis skin test) administration and interpretation

Tele Visits

Consults

I understand that my child needs to provide proper identification (driver's license, learners permit, school ID) at the time of the visit. My child will NOT be seen without proper identification.

If a provider needs to call me while my child is being seen, you can contact me at:

Phone number: _____

This form remains in full effect until rescinded in writing by parent or legal guardian.

Parent/Legal Guardian Signature: _____

Parent/Legal Guardian Name: _____