Mountain View Pediatrics
77 West Forest Avenue, Suite 304
Flagstaff, AZ 86001
(928) 214-3600

Patient Name: _____
Date of Birth: _____
Parent/Guardian Name: _____

Consent for Medical Treatment by Authorized Person(s)

In the event a parent or guardian is unable to attend a visit for my child at Mountain View Pediatrics, I give the below named individual(s) power and authority to consent to medical treatment.

_____ _____
Name Phone Number
_____
Relationship to Child

_____ _____
Name Phone Number
_____
Relationship to Child

_____ _____
Name Phone Number
_____
Relationship to Child

This grant of temporary authority is effective as dated below and shall remain effective until terminated by the undersigned in writing. I agree to the following:

1. The individual(s) above may obtain medical treatment and procedures for my child as appropriate in emergency circumstances, including treatment by physicians, hospital, and clinic personnel, and other appropriate health care providers
2. The individual(s) above may obtain routine medical treatment from appropriate healthcare providers if symptoms of illness occur (e.g., fever, coughing, irregular breathing, unusual rashes, swallowing problems, etc.)
3. The individual(s) above will be responsible for any charges incurred regarding copays or deductibles as put forth by the child's insurance policy.

_____
Patient's Name

_____
Print Name of Parent or Legal Guardian

_____ _____
Parent or Guardian Signature **Date**