Kids First Pediatric Clinic, LLC
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AUTHORIZATION FOR MEDICAL TREATMENT OF MINORS

(Other than Parent or Guardian)

I_____give permission for my child/children to be medically evaluated and treated at A Kids First Pediatric Clinic in my absence. I understand that it may be necessary to perform diagnostic tests in the course of the evaluation.

Patient Name_____ Date of Birth _____

Patient Name_____ Date of Birth _____

Patient Name_____ Date of Birth _____

Patient Name_____ Date of Birth _____

I/We, the parent(s) or legal guardian(s) of the above named minor(s), do hereby appoint the following adults to act on my/our behalf in authorizing medical, surgical care and hospitalization for the above named minor(s) during the period of my/our absence from:_____to_____.
Date Date

Name of appointed Adult	Relationship to Patient	Phone Number
Name of appointed Adult	Relationship to Patient	Phone Number

This consent applies to but not limited to:
Complete physician check-up (including blood and urine samples), Hearing, vision, VEP, Immunizations, First aid and emergency care, Prescription and treatment for illness, Referrals to an outside agency (for example: hospital, radiology) for services not provided at the office. This document shall be presented to a physician or appropriate hospital representative at such time as medical, surgical care or hospitalization may be required.
In case of emergency, I can be reached at: (Contact Number): _____

FINANCIAL RESPONSIBILITY

I/We understand that payment is expected at the time of services and will ensure that the above mentioned appointed caretaker has the required insurance information and the means to pay the co-pay/co-insurance due at the time of service. I/We accept full responsibility for the charges accrued in the healthcare of my/our children if the physician, hospital, or other ancillary healthcare provider is unable to collect from my/our insurance company.

Signature of Parent/Legal Guardian Printed Name of Parent/Legal Guardian Date

_____ _____ _____