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**AUTHORIZATION TO TREAT MINOR PATIENT IN ABSENCE OF PARENT/GUARDIAN**

I, \_\_\_\_\_, the parent or legal guardian of:

\_\_\_\_\_ DOB \_\_\_\_\_      \_\_\_\_\_ DOB \_\_\_\_\_  
\_\_\_\_\_ DOB \_\_\_\_\_      \_\_\_\_\_ DOB \_\_\_\_\_  
\_\_\_\_\_ DOB \_\_\_\_\_      \_\_\_\_\_ DOB \_\_\_\_\_

Hereby authorize:

\_\_\_\_\_ Relationship to patient \_\_\_\_\_  
(Name of person bringing child to office) Phone number \_\_\_\_\_  
\_\_\_\_\_ Relationship to patient \_\_\_\_\_  
(Name of person bringing child to office) Phone number \_\_\_\_\_  
\_\_\_\_\_ Relationship to patient \_\_\_\_\_  
(Name of person bringing child to office) Phone number \_\_\_\_\_

to accompany my above-named child(ren) to office visits with the physicians at Pediatric Care Corner and consent to the examination and/or treatment of my child(ren) during office visits. This authorization includes the administration of necessary medication as well as any recommended immunizations.

This authorization:

- Is effective from \_\_\_\_\_ to \_\_\_\_\_
- Is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time in writing to Pediatric Care Corner.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date