AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Full Legal Name of Minor:_____
Last First Middle Initial

Minor's Date of Birth:_____

I hereby authorize_____ related to the minor as _____ _____, to consent to such regular health care, including immunization procedures and allergy treatments, on the minor's behalf as it is necessary for the minor's health and best interests. I also authorize the above named person to act on my behalf in case the minor experiences a reaction to the authorized treatments or is a victim or injury or illness when immediate medical or surgical care is needed, provided diligent effort is made to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize the above named person to take such action and give such consent on the minor's behalf as that person's reasonable judgment dictates.

I understand that this consent will last for one year unless I choose to withdraw my consent before that time. A revocation of this authorization must be submitted in writing. If I withdraw consent, it will not affect actions already taken by authorized person.

_____
Signature(s) of person(s) granting authority to consent

_____ _____
Date **Relationship to minor**

Mother's Name: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

Father's Name: _____
Address: _____
_____
Home Phone: _____
Cell Phone: _____
Work Phone: _____

***Additional information required:*
Copy of front and back of insurance card
Immunization record
Pertinent medical history/medication list
Allergies