Fellsway Pediatrics

Authorization for Medical Treatment of a Minor

I, the parent or legal guardian of _____ born
(Child's name)
_____, a minor, do hereby appoint
(Birth date)
_____ to act on my behalf in the event I cannot be contacted to
(Care givers name)
Authorize necessary medical treatment while said minor is under his/her care beginning on
_____ and ending on _____.
(Start date) (End date)
I will be responsible for paying costs associated with such treatment.

_____

Signature of parent or Legal Guardian

_____

Printed Name of parent or Legal Guardian

_____

Relationship to Child

_____

Home Address

_____

City, State, Zip Code

_____

Home Phone Number

_____

Cell Phone Number