

## AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT OF A MINOR UNACCOMPANIED BY PARENT OR LEGAL GUARDIAN

In my absence, I	, who has legal custody of		
my child,	and whose date of birth is		
authorize	to provide consent to ABC Pediatrics to render care under		
the supervision and advice of a licensed medical care professional. I understand that it may be necessary to perform diagnostic testing and/or to administer vaccinations in the course of the visit.  I consent to all medically services rendered during the visit for example, physical examination, hearing and vision testing, immunizations, treatment for illness, referrals to a specialist, etc. The above named person may also receive any tests results and any additional medical information pertinent to the care and treatment of the minor child.  I do not consent to the following services:			
		This written consent is valid for the time period	l of:
		After a period of one year, a new consent form revoked by me at any time in writing.	would need to be completed. This consent may be
Parent or Legal Guardian's Name	Date		
Parent or Legal Guardian's Signature	Date		
	<del></del>		

Phone Number Where Parent or Guardian Can Be Reached