



The Children's and Family Health Center  
Medicine Pediatric Practice

**"Authorization to Treat Child Without The Parent/Guardian Present"**

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Revised Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To Whom It May Concern:

In the event I \_\_\_\_\_  
Name of parent/legal guardian Relationship to child

am not present at the time of my child's medical appointment, I hereby authorize the following person(s) to represent me and render their consent so my child can receive medical treatment by a provider at the Medicine Pediatric Practice of the Children's and Family Health Center.

I realize that my child will not be seen:

- If the "Authorization To Treat Child Without The Parent/Guardian Present" form is not completed at the initial visit or I refuse to name someone to represent me.
- If the child is an established patient and I refuse to name someone to represent me.
- If someone other than the person/persons listed below comes in with my child.
- If the person does or will not show a proper form of identification.

This authorization will remain valid until The Medicine Pediatric Practice of the Children's and Family Health Center is notified in writing by the above name authorized parent/guardian.

Patient's Name: Last First Middle

Patient's Date of Birth: Month Date Year

**I hereby authorize the following person/persons to give the Medicine Pediatric Practice consent to render treatment to my child.**

1. \_\_\_\_\_  
Name Relationship to Patient

2. \_\_\_\_\_  
Name Relationship to Patient

3. \_\_\_\_\_  
Name Relationship to Patient

Name: \_\_\_\_\_  
Printed Relationship to Patient \_\_\_\_\_

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_