Authorization to Consent to Treatment of Minor

The purpose of this form is to give the designated agent(s) the power and authority to consent to medical treatment for my child.

- Name of Child: _____
- Child Date of Birth_____
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- My agents may consent to my child's

  - ☐ Examination / Physical
  - ☐ COVID-19 Testing
  - ☐ Xrays
  - ☐ Medication
  - ☐ Procedures
  - ☐ Transportation by ambulance

- This power and authority will be effective as of _____

  This consent will remain in effect until it is revoked by notifying the medical facility in writing.

- Legal Guardian Name: _____
- Legal Guardian Phone Number: _____
- By signing this form, I make oath and say that I am the lawful guardian of the minor listed below and there are no court orders in effect that would prohibit me from conferring the power to consent upon another person. I authorize and appoint the individual(s) listed above, the power and authority to consent to medical treatment for my child.

- Legal Guardian Signature: _____

AFC Urgent Care
475 Hurfville Crosskeys Rd., Suite B. Sewell, NJ 08080.
Phone: 856-553-6611. Fax 856-956-3122