General Consent for Treatment of a Minor Not Accompanied by Parent or Legal Guardian

Completion of this form is required if a parent / legal guardian of a minor desires to provide consent to routine treatments and procedures for a minor while in the care of an authorized individual designated by the parent/legal guardian.

I, the undersigned parent/legal guardian of ______________________________(Minor), whose Date of Birth is_____/_____/________, may not be able to accompany the Minor when he/she requires medical care. I therefore hereby authorize your staff to perform treatments and procedures on said Minor, as determined by the physician to be medically necessary, when the Minor is accompanied by the authorized adult named below.

Authorized Adult: ______________________ Relationship to Minor: ______________________

Address: ____

Telephone Number: ______________________

I further authorize you to discuss any Protected Health Information regarding treatment of the Minor with the authorized individual named above.

If there is a need to reach me during the Minor's appointment to discuss further care or treatment, I may be reached at the following phone numbers:

Cell Phone: ______________________ Home Phone: ______________________

Please note the Minor's allergies and/or medical conditions below which must be considered in his/her treatment.

Allergies *(insect, food, medication, etc.)*	Reaction to allergy

Medical Condition	Current Medication

I understand that this authorization remains in effect until I provide a written request to revoke.

Parent/Legal Guardian Name *(Please Print)*: ______________________________

Address: ____

Signature: ______________________________ Date: ______________

(Parent/Legal Guardian)

This AFC location is owned and operated by:

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