



## Medical Treatment Authorization and Consent Form

The following form is designed for those situations where minors are unaccompanied by either their parent or by their legal guardian. This Medical Treatment Authorization and Consent Form gives authority to a designated adult (must be at least 18 years of age) to make medical decisions in the absence of said minor's parents/legal guardians.

\_\_\_\_\_  
Minor's Name

\_\_\_\_\_  
Minor's Date of Birth

I, signing as legal guardian of above said minor, authorize the following adults to bring my child to Associated Pediatrics of Fox Valley, and/or any other qualified healthcare providers, labs or hospitals, in my absence. I am giving them the authority to make medical decisions, including but not limited to, immunizations, labs, coordination of care, emergency care and all other care deemed medically necessary, on my behalf.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Minor

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Minor

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship to Minor

This authorization will be effective indefinitely unless revoked, in writing, by myself.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

Emergency Contact Number: \_\_\_\_\_