Chattahoochee Pediatrics
~Caring for the Whole Child~

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MEDICAL TREATMENT AUTHORIZATION FOR A MINOR

I, the undersigned parent, hereby grant authority to the care provider(s) listed below to obtain treatment for the following child(ren):

NAME:_____ DOB:_____
NAME;_____ DOB:_____
NAME:_____ DOB:_____
NAME:_____ DOB:_____

The care provider(s) below shall have the authorization to:

-obtain medical treatment and procedures for the child(ren) as may be appropriate in emergency circumstances, including treatment by physicians and clinic personnel, and other appropriate health care providers.

-obtain routine medical treatment from appropriate health care providers if symptoms of illness occur.

This grant of temporary authority shall begin on _____, and shall remain effective until terminated by the undersigned.

Authorized care provider(s) include:

NAME:_____RELATIONSHIP TO CHILD:_____
NAME:_____RELATIONSHIP TO CHILD:_____
NAME:_____RELATIONSHIP TO CHILD:_____

PARENT SIGNATURE:_____ DATE:_____

PREFERRED PHONE: _____
ALTERNATE PHONE:_____