MINOR CHILD MEDICAL AUTHORIZATION FORM

It is the policy of Michigan Pediatric Ear, Nose, & Throat to have a parent or legal guardian present during a minor patient’s initial visit. This helps the parent/guardian have a comprehensive understanding of your child’s care and treatment options.

In the event that you, as a parent or guardian cannot be present during a future visit(s) please complete the below listed authorization for the care of your child.

I, the parent/guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize (name of person to accompany child) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, to authorize any and all medical treatment for (name of minor child) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. This includes but not limited to examination and treatment.

A photocopy of this authorization shall be deemed effective as if it were original. This authorization shall remain in effect for one year.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Date