PEDIATRIC PERMISSION FOR MEDICAL TREATMENT FORM

JHC will provide medical care for a child in the absence of the parent or legal guardian when the parent or legal guardian designates an individual who is 18 years or older to represent them.

Patient Name ____ DOB________________

I, (print name of parent/guardian) ____,
give the following person:

Name: ____

Relationship: ____

Address: ____,

the authority to act on my behalf and he/she may give consent to emergency medical treatments and perform the following (please initial all that apply):

_____________ Bring in for appointments
_____________ Consent for Immunizations to be given
_____________ Pick up Prescriptions
_____________ Consent for blood work to be drawn
_____________ Receive test results
_____________ Other____

I understand that all individuals who act in my absence must show a picture ID as identification.

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Signature of parent/guardian Date