



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 individual(s) the authority to act on my behalf:

1. Name: _____ Relationship: _____

Address: _____

May give consent to emergency medical treatments and perform the following:

- Bring in for appointments
- Consent for Immunizations to be given
- Pick up Prescriptions
- Consent for blood work to be drawn
- Receive test results
- Other: _____

2. Name: _____ Relationship: _____

Address: _____

May give consent to emergency medical treatments and perform the following:

- 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.

I may revoke my consent at any time, in writing. Unless revoked earlier, this consent will expire one year from the date signed.

Signature of parent/guardian: _____ Date: _____