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
   - ☐ Consent for Dental Treatment
   - ☐ 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
   - ☐ Consent for Dental Treatment
   - ☐ 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: ________________