FENTON MEDICAL CENTER

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

Date: ______________________________

Patient Name: ____ DOB: ______________________

I hereby authorize ____ (related to the above-named minor as his/her ____) to consent to regular health care. No immunizations will be given without a parent or legal guardian at the visit.

I authorize the above-named person to act in my behalf in case the minor experiences a reaction to the authorized treatments or is a victim of injury or illness when immediate medical or surgical care is needed, provided diligent effort is made to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize the above-named person to take such action and give such consent on the minor's behalf as that person's reasonable judgment dictates.

I understand that this consent will only cover today's visit.

____ ______________________

Signature of person who is granting authority to consent Date

(Birth parent or legal guardian)

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Relationship to minor