COASTAL PEDIATRIC MEDICAL GROUP

Authorization for Minor Child between 15-18 years of age to be Treated **Without any Adult Present**

I am the legal guardian/ parent of:

_____ _____

Patient's Name Date of Birth

I believe my adolescent child is capable of making decisions about their own healthcare. This authorization permits the young adult named above to consent for: (**PARENT MUST INITIAL EACH**!)

_____ Medical care _____ Antibiotic injections _____ Labs

_____ Vaccinations _____ Prescriptions

This authorization will remain in force until revoked in writing by me. I hereby attest that I have the legal authority to delegate my authority to consent for care, and that no legal agreement prevents me from delegating authority.

_____ _____

Parent/Guardian Signature Date

_____ _____

Printed Name ` Relationship to patient