COASTAL PEDIATRIC MEDICAL GROUP

Authorization for Non-Parent Adult to Consent to Care for Minor

I am the legal guardian/ parent of:

Patient's Name	Date of Birth

I authorize the following person(s) to seek medical care for the above listed child(ren):

Name:	Relationship to patient:
Name:	Relationship to patient:
Name:	Relationship to patient:
Name:	Relationship to patient:

This authorization permits the above-named persons 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