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Pediatric and Adolescent Medicine

MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

The following form is designed for those situations where minors are unaccompanied by either parents or legal guardians. This "Medical Treatment Authorization and Consent Form" gives authority to a designated adult to arrange for medical care for a minor in the event of an emergency and/or for routine medical treatment for symptoms of illness (e.g. fever, cough, irregular breathing, unusual rash, sore throat etc).

_____
Minor's Full Name

_____
Minor's Address

_____
City, State, Zip Code

_____
Minor's DOB

The undersigned do hereby authorize _____ as agent for the undersigned to consent to medical treatment deemed advisable by Northampton Area Pediatrics, LLP, for the above listed minor child.

This authority shall begin on _____ (date) and shall remain in effect until

_____ (date, but no longer than 12 months).

_____
Parent or Guardian Signature *Date*

_____
Parent or Guardian (please print)

_____
Address Parent or Guardian

_____
Home, Cell and Work Phones of Parent or Guardian

_____
Witness Signature *Date*

_____
Witness (please print)