

NORTHAMPTON AREA PEDIATRICS, LLP

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Pediatric and Adolescent Medicine

Medical Consent Authorization / Limited Power of Attorney

Child's Full Name: _____

Date of Birth: _____

Parent/Legal Guardian Name: _____ Phone Number: _____

Temporary Guardian/Responsible Adult Name: _____

Relationship to Child: _____ Phone Number: _____

Dates of Authorization:

From: _____ To: _____ **Optional Notary** – No more than 30 days; **Notary Required for >30 days up to 12 Months.** * This authorization automatically expires on the 'To' date listed above unless revoked earlier in writing. This authorization automatically terminates when the child reaches eighteen (18) years of age.

Authorization to Consent to Medical Treatment

I, the undersigned parent/legal guardian of the above-named child, authorize the individual named above to consent to the following medical treatments while I am unavailable:

Please check all that apply:

Emergency care (non-life threatening) Administration of prescription medications Diagnostic procedures (e.g., Strep/Covid) Routine non-emergency medical treatment Treatment necessary for relief of pain or infection (OTC) Wart Treatment Cerumen (wax) Removal Laceration Repair Minor Surgery (abscess draining etc) Preventive care/well visits (including additional screenings not limited to hearing, vision, developmental / behavioral screenings) Mental health services * **Only the categories checked above are authorized**

* Hospital-based procedures require separate facility-level consent.

Authorization for Immunizations

Please check all that apply:

Routine childhood immunizations (per age-appropriate CDC schedule)
 Influenza (Flu) vaccine COVID-19 vaccine

***Only the vaccines checked above are authorized**

Medical Consent Authorization / Limited Power of Attorney (continued)

Allergies, Medications, or Special Health Concerns:

Parent/Guardian must initial each statement below.

_____ I authorize Northampton Area Pediatrics, LLP to disclose protected health information regarding my child to the above-named authorized adult for purposes of treatment, payment, and healthcare operations during the effective dates of this authorization.

_____ I affirm that no court order currently in effect restricts my authority to grant this consent.

_____ This authorization may be revoked at any time by written notice to Northampton Area Pediatrics, LLP.

_____ I understand that I remain financially responsible for services rendered.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Notary

Optional Notary – No more than 30 days; **Notary Required for** >30 days up to 12 Months.

State of _____

County of _____

Subscribed and sworn before me on this _____ day of _____, 20____
by _____ (Parent/Guardian Name).

Notary Public Signature: _____

My Commission Expires: _____

Situation	Recommended Form	Duration
Short vacation/travel	Medical Consent Authorization / Limited POA	1–30 days
Extended visit (30 days - 12 months)	Medical Consent Auth/Limited POA + Notary	>30 days up to 12 Months
Minor is residing with the caregiver	Caregiver Authorization or Legal Guardianship*	Up to 2 years

* Caregiver Authorization permitted only when statutory co-residency requirements are met under MGL c. 201F.