FOCUS PEDIATRICS
WHERE THE FOCUS IS ON YOU
www.focuspeds.com

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Authorization to consent to medical treatment of a minor

Patient name: _____ Patient DOB: _____

When a parent and/or guardian is not present, I hereby authorize the following individual(s) to bring my child to Focus Pediatrics, LLC and to consent to medical treatment on my behalf:

Name: _____
Relationship to Child: _____
Phone: _____

Name: _____
Relationship to Child: _____
Phone: _____

This authorization includes, but is not limited to:

- Routine well and sick visits
- Vaccinations
- Lab testing
- Prescriptions
- Any urgent care or follow-up treatment deemed necessary by the provider

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Limitations or Special Instructions (if any):

_____

_____

_____

This authorization is:

☐ Valid for a single visit only on _____

☐ Valid until the following date: _____

☐ Valid until revoked in writing

Acknowledgement

I understand that Focus Pediatrics, LLC will make reasonable efforts to contact me in the event of an emergency or if further consent is required. I release Focus Pediatrics, LLC and its staff from any liability arising from reliance on this authorization.

Signature: _____ Full name: _____

Mobile #: _____ Email address: _____

Date: _____ Patient relationship: _____