Family Care
Walk In Clinic

Authorization Form for Medical Treatment of Minors

If your child needs medical treatment, permission must be given by a parent. This document allows you to appoint relatives or caregivers, **over the age of 18**, permission to consent to medical treatment of your child.

To alleviate treatment delays, please confirm that everyone listed below has adequate personal and family medical history knowledge on the minor, as well as a current medication list, and that they are aware of any allergies. All person(s), including the parent, should present a photo I.D. each time they bring a child for treatment. If they do not have a photo I.D. we will need 2 different forms of non-photo I.D. (credit cards, social security card, etc.) with the same name.

Full name of minor: _____ DOB: _____

Please list any person(s) who have permission to consent to medical treatment for the above minor.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____, hereby authorize the above person(s) permission to consent to
(Parent or Guardian)
medical treatment for _____ in my absence.
(Minor)

Signature of Parent or Guardian: _____ Date: _____

If your child is over the age of 16 and you would like to give permission to treat him/her without the presence of a parent or authorized person(s) please fill out the section below.

I, _____, hereby authorize Family Care Walk-In Clinic to treat
(Parent or Guardian)
_____, who is over the age of 16, without a parent or authorized person(s)
(Minor)
present at the time of treatment.

Signature of Parent or Guardian: _____ Date: _____