First Steps™
PEDIATRICS & ADOLESCENT MEDICINE

Treatment Authorization Form for Minors

Patient Name: _____Date of Birth:_____

I (we) consent to any necessary examination, anesthetic, medical or surgical treatment, and/or hospital care to be rendered to the above named minor under the supervision and on the advice of a duly licensed physician during the period of my (our) absence. This form gives my legal consent for treatment.

Parent(s) Signature(s): _____
Date

_____
Date

The following individuals have my (our) permission to bring the above named child to the Physician's Office for Well Child Exams, Immunizations, Allergy injections, or any treatments deemed necessary by the physician after evaluation of the child.

NAME OF INDIVIDUAL	RELATION TO CHILD
1_____	_____
2_____	_____
3_____	_____
4_____	_____
5_____	_____
6_____	_____

Any additions or deletions of this form are the sole responsibility of the parent.

Thank You.