Plan Ahead!

The Pediatric Center

Authorization To Consent For Treatment Of A Minor

Must be completed by biological parent(s) or legal guardian(s)

ID REQUIRED

It is important to remember that a child under 18 years of age who needs medical, dental or hospital care cannot be treated without a parental permission unless the situation threatens the child's life or limb. That's the law.

To ensure that your child receives the proper care in your absence, you can appoint anyone over 18 years of age to authorize your child's medical care and make medical decisions on your behalf.

Please complete the information below & provide a copy of your Picture Id

I ,_____authorize the following individual(s),

(Name of Parent or Legal Guardian)

Name: _____ Relationship to child: _____

Photo Id required

to consent to medical treatment for my minor child/children listed below:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

This authorization expires on _____ _____ _____

Month Day Year

If left blank, authorization expires a year from the date signed.

PARENTAL CONTACT INFORMATION

If the nature of the medical care is not routine. Please try to contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable for any reason to contact me (us), you may rely on the proxy decision maker for consent.

_____ _____

Parent name (TYPE) Contact #

_____ _____

Signature of Parent or Legal Guardian Date

_____

Witness /Employee Name

Immunizations Consent

please see the following page

Consent to Proxy for Vaccines

I, parent of legal guardian _____authorize the following individual(s),

Name: _____ Relationship to child: _____

Photo Id required

to consent to medical treatment including vaccinations for my minor child listed below:

Name: _____ Date of birth: _____

I authorize the following to be administered to my child without my presence:

☐ All Vaccines recommended by the CDC and AAP

☐ NO vaccinations can be administered without a parent or legal guardian consent

Only the following can be administered without parent or legal guardian

Please select:

□ Hepatitis B (HepB)
□ Rotavirus*2* (RV) RV1 (2-dose series); RV5 (3-dose series)
□ Diphtheria, tetanus, & acellular pertussis*3* (DTaP: <7 yrs)
□ Tetanus, diphtheria, & acellular pertussis*4* (Tdap: ≥7 yrs)
□ Haemophilus influenzae type b*5* (Hib)
□ Pneumococcal conjugate*6* (PCV13)
□ Pneumococcal polysaccharide*6* (PPSV23)
□ Inactivated poliovirus*7* (IPV: <18 yrs)
□ Influenza*8* (IIV; LAIV) 2 doses for some
□ Measles, mumps, rubella*9* (MMR)
□ Varicella*10* (VAR)
□ Hepatitis A*11* (HepA)
□ Human papillomavirus*12* HPV2 □HPV4
□ Meningococcal*13* (Hib-MenCY ≥ 6 weeks; MenACWY-D ≥9 mos; MenACWY-CRM ≥ 2 mos

_____ _____

Parent name (TYPE) Contact #

_____ _____

Signature of Parent or Legal Guardian Date

_____

Witness /Employee Name