Care of Unaccompanied Minor: Consent to Treat

It may be more convenient to have prior authorization in place so that medical care may be delivered directly to minors if a parent or legal decision maker cannot be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment for your minor child.

AUTHORIZATION

I have the legal right to preauthorize this facility to deliver medical treatment to my (our) child. I request and authorize Physicians to Children, Inc. and its personnel to deliver care to my child listed below. I understand that I am financially responsible for all charges incurred for services rendered whether or not they should be paid for by insurance or by someone else. I do hereby indemnify and hold harmless the provider and other persons who act in reliance upon this authorization.

Name _____ Date of Birth _____

Medications _____

Allergies _____

Pertinent Medical History _____

LIMITATIONS

Identify the type of medical services for which this authorization is given.

Date of service _____

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CONTACT INFORMATION:

Parent's Name _____

Daytime Phone _____

Evening Phone _____

Cell Phone _____

_____

(Signature of Parent or Legal Guardian)

Date _____