AUTHORIZATION TO CONSENT FOR TREATMENT OF A MINOR

TO: France Avenue Family Physicians

RE: _____, a minor.

Date of Birth: _____ Medical Record Number: _____

I hereby authorize _____related to the above-named minor as his/her _____ to consent to such regular health care, including immunizations, procedures and lab testing on the minor's behalf as is necessary for the minor's health and best interests.

I also authorize the above-named person to act on my behalf in case the minor experiences a reaction to the authorized treatments or is a victim of injury or illness when immediate medical or surgical care is needed, provided diligent effort is made to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I authorize the above-named person to take such action and give such consent on the minor‘s behalf as that person's reasonable judgment dictates.

I understand that this consent is in effect for one year unless I change my mind and withdraw my consent in writing. If I withdraw consent, it will not affect actions already taken by France Avenue Family Physicians

Date: _____

Signature of person who is granting authority to consent: _____

Printed Name: _____

Relationship to Patient: _____