CONSENT AUTHORIZATION

Medical Care for a Minor Child

Wakefield Pediatrics
Boston Children's
Primary Care Alliance

wakefieldpedi.com
781-245-2203 | *fax* 781-245-7303

Dates of authorization

Today's date: _____

This authorization is valid:

❍ For one year from today's date

❍ Until another date: _____

Authorization

I/We, do hereby state that I/we are the parent(s)/guardian(s) have legal custody of the child/children listed below, and authorize the designated entrusted adult to consent to all necessary and appropriate medical care, including but not limited to diagnostic examination, immunizations, anesthetic and hospital care to be rendered to the minor at a recognized medical facility under the general or special supervision of a licensed physician.

I understand that if an injury/illness is determined to be life threatening, my provider will make every effort to contact me. If I am unreachable, the above entrusted adult may consent to emergency care for my child.

By my signature, I acknowledge that I have read and understand this consent to authorize medical care to my minor child/children.

Parent/Guardian #1: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Parent/Guardian #2: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Child #1 name: _____

Date of birth: _____

Describe medical history, allergies, medications:

_____

_____

_____

_____

Child #2 name: _____

Date of birth: _____

Describe medical history, allergies, medications:

_____

_____

_____

_____

Child #3 name: _____

Date of birth: _____

Describe medical history, allergies, medications:

_____

_____

_____

_____

Name of adult into whose care minor(s) is/are entrusted:

_____

Their relationship to child/children:

_____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____

Signature of parent/guardian:

_____