First Med
URGENT CARE

Authorization for Medical Care to Minor(s)

I/We, the undersigned, parent(s) or legal guardian of the minor(s) listed below:

_____ _____
Name Date of Birth

_____ _____
Name Date of Birth

Do hereby authorize an x-ray exam, anesthetic, medical, or surgical diagnosis or treatment by any licensed provider that may be rendered to said minor under the general, specific or special consent of:

_____
Name of Adult Person who is Temporary Custodian of Minor(s)

The Temporary Custodian of the minor: whether such diagnosis or treatment is rendered at the office of the provider. I/We authorize the provider to call in any necessary consultants in his/their discretion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but it is given to encourage those persons who have temporary custody of the minor and said provider to exercise his/their best judgement as to the requirements of such diagnosis or medical, or surgical treatment.

Furthermore, I agree to pay the costs of any medical care that is provided in reliance on this authorization to consent.

This consent shall remain effective until _____ a.m./p.m. on day of _____, 20___ unless sooner revoked in writing, delivered to said physician or dentist or to said persons entrusted with the custody, care and control of said minor child or children.

Dated: _____ Mother/Father/Legal Guardian
Circle which apply

Legal guardian's name: _____

Legal guardian's DOB: _____ _____Social Security #_____

Relationship to minor: _____Contact # _____

Signed: _____

Witness: _____