THE POLYCLINIC

AUTHORIZATION TO CONSENT FOR TREATMENT OF A MINOR

In my absence I hereby authorize the following adult(s) to accompany my child and to provide consent to medical or surgical treatment for my child_____.

PLEASE COMPLETE:

_____ _____

Print Name Relationship to patient

_____ _____

Print Name Relationship to patient

CONSENT TO CARE FOR AN UNACCOMPANIED MINOR

In my absence I hereby provide consent to The Polyclinic authorization to provide needed medical or surgical care treatment for my child_____.

Such consent to either section noted above may include, but is not limited to: clinic visits; medical treatments; tests; imaging studies; including xrays; transfusions; injections; immunizations; medications and performing of whatever procedures may be deemed necessary or advisable.

It is understood this authorization is given in advance of any specific diagnosis, treatment or hospital care being required. It is given to provide the Polyclinic and it 's clinical staff authorization to provide medical care they may deem advisable in the exercise of their best judgement.

This authorization shall remain effective until revocation in writing by the undersigned.

I acknowledge that I am responsible for all changes in connect with the care and treatment rendered to the above minor. if the insurance card and co-pay (if applicable) is not provided in advance of the treatment, The Polyclinic may require and advance deposit.

_____ _____

Parent/Legal Guardian Printed Name Parent/Legal Guardian Printed Name

_____

Today's Date

_____

Medical Record of Minor *(to be completed by Polyclinic staff)*