CLAYTON
PEDIATRIC CENTER

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Child Medical Authorization Form

Name of Patient: _____ Date of Birth: _____

I am the parent or guardian of _____ (legal name of patient). I have the legal right to consent for medical treatment for this child (patient).

I authorize the following individual, who is a person over 18 years of age and whose relationship to the child is:

_____ _____
Person bringing child to appointment Relationship to child

to bring the child to his or her medical appointment, and to consent to medical care which is deemed necessary by the physicians and medical providers at Clayton Pediatric Center at the time of the appointment. I understand that this delegation includes receiving health information about the minor necessary to make immediately necessary health care decisions.

This consent is valid until revoked in writing by me, the parent or legal guardian.

_____ _____ _____
Signature of Parent or Guardian Printed Name Date

Contact information for parent/guardian: _____
Phone Number