CAREMOUNT MEDICAL

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Authorization for Treatment of a Minor in the Absence of Parent or Legal Guardian

I, _____, the parent or legal guardian of

_____, _____hereby authorize
Print Name DOB

Dr._____to diagnose and treat my child.

This authorization includes, but is not limited to, consent for physical examination, vaccinations and injections, medical treatment, minor medical procedures, and any emergency care and treatment including diagnostic X-rays or where a delay in reaching me would endanger or seriously increase the risks to my child. Other specific treatments and/or procedures that I consent to are as follows:

_____
Please list any additional treatments or procedures

☐ I will be unavailable from _____ to _____ and this authorization remains in effect until the latter date.

_____ _____
Date Parent/Legal Guardian Signature – please circle one

_____ _____
Date Witness Signature