MEDICAL TREATMENT AUTHORIZATION FORM

This form grants temporary authority to a designated adult to provide and arrange a medical visit for a minor, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them or have them accompany the minor to the physician's office. **This form must accompany the minor to the visit.**

MINOR

Full Legal Name: ______________________________ Date of Birth: __________

Home Address: ____

INFORMATION FOR MEDICAL TREATMENT

Practice Name and Location: The Kids Clinic 4411 Fremont Ave N, Seattle, WA 98103

TREATMENT

Explicitly identify what conditions child can be treated for during visit:

____

AUTHORIZATION AND CONSENT

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for:

Name: _______________________ Drivers License Number: _______________

to transport and accompany Minor to the Physician office for the Treatment. I agree to assume financial responsibility for all expenses of such care. I agree to be available during the scheduled physician's visit at the following phone number: ______________________

This authorization is effective on date _____ / _____ / _______ (not to exceed one day)

Parent / Legal Guardian Signature: ____________________________________

Parent / Legal Guardian Printed Name: __________________________________

4411 Fremont Ave. N. Seattle, WA 98103
Phone: 206-957-1881 ● Fax: 206-834-6013