NORTHCREST FAMILY MEDICINE

AUTHORIZATION FOR OTHERS TO CONSENT TO TREATMENT OF MINOR CHILD

We the undersigned, recognize that it may be necessary or desirable for our children to receive medical treatment, including minor surgery and invasive procedures or diagnostic tests at the time when we are unavailable and are therefore then unable to authorize such treatment of our children.

Therefore, we delegate to the person who has custody or physical possession of our children during our absence the right to exercise our power of consent as to any and all aspects of the examination, diagnosis and administration of medical treatment, for our children, by the personnel of Northcrest Family Medicine, or any medical facility designated by such personnel.

We acknowledge and agree that this Authorization shall remain in effect until we notify Northcrest Family Medicine in writing that we are revoking it.

Names/D.O.B. of Children:

______________________ DOB _________

______________________ DOB _________

______________________ DOB _________

______________________ DOB _________

Parent/Guardian Consent (Print) Date

__________________________ ____________

Parent/Guardian Consent (Signature) ____________

Phone Numbers Where You Can Be Reached

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