Authorization for Medical Treatment of a Minor

Fellsway Pediatrics
Boston Children's
Primary Care Alliance

fellswaypediatrics.com
781-665-4364

I, the parent or legal guardian of:

Child's name: _____ , born

Birth date: _____ ,

a minor, do hereby appoint

Care giver's name: _____

to act on my behalf in the event I cannot be contacted to authorize necessary medical treatment while said minor is under his/her care beginning on _____and ending on _____

I will be responsible for paying costs associated with such treatment.

Signature of parent or legal guardian:

_____

Printed name of parent or legal guardian:

_____

Relationship to child: _____

Home address: _____

City: _____ State:_____

Zip:_____

Home phone:_____

Cell phone: _____