Partial Parental Delegation of Authority for Treatment Form

In order to provide safe and effective treatment to patients under the age of 18 a parent or legal guardian must accompany underage patients to their appointments. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian stating that this person has been appointed by you to act on your behalf.

You may appoint anyone who is over the age of 18 years of age to be responsible for your child when you are unable to accompany them to their medical appointment.

Consent to treat a minor will be appointed for one year unless otherwise stated

Patient (Minor) Full Name (Printed) _____

Patient (Minor) Date of Birth _____

I hereby authorize:
Name & Relationship (Print) _____

Name & Relationship (Print) _____

☐ To bring the named minor in for examination and treatment, including well child checks, at Valley-Wide

☐ To Consent to medically necessary invasive procedures

☐ To administer medications if medically necessary

☐ To administer vaccinations

I understand that by signing this form I am authorizing the individual(s) named above to consent to treatment for my minor child, on my behalf. I also acknowledge that by signing this form I am stating that I have the legal authority to authorize the individual(s) named above to sign/authorize treatment on my behalf.

I reserve the right to revoke this authorization at any time in writing otherwise the consent is valid for one year.

Parent or Legal Guardian Name (Printed) _____

Parent of Legal Guardian Name Signature_____

Date_____

*A Separate form is required for each child for which authority is being delegated
*A Completed Health History Form must accompany this form