Authorization for Treatment of Minors

Thank you for choosing Jackson Pediatric Associates (JPA) as your child's pediatricians. Please review our current office policy regarding the treatment of your minor child(ren). Once you have carefully read the following please sign this document and return to our office staff. If you have any questions, do not hesitate to ask one of our staff members.

Name of Minor Children Birth Date

Parent Names:

I/We, the biological parent(S) or legal guardian(s) of the above named children give permission for JPA to provide medical treatment as necessary for my child's health, including evaluations, perform diagnostic procedures and provide medical treatment as deemed necessary by the Attending Provider. This authorization also includes administering vaccines, obtaining specimens of blood, urine and other body fluids, tissues of products for the purpose of tests and/or procedures. **I authorize JPA or their representatives to act on my behalf, in providing my child such care when I cannot be contacted.**

We/I will be responsible to provide JPA with up to date pertinent history & condition information prior to each appointment & to make arrangements to receive follow up instructions & treatment plans. If such efforts to communicate with me are unsuccessful, I authorize Jackson Pediatric Associates to take appropriate action & give consent on my behalf as his/her judgement dictates.

This authorization may be cancelled at any time, and shall remain active until such time it is cancelled in writing, or a new updated authorization is received. **I/We understand that we are responsible for all reasonable charges in connection with the care & treatment of my children listed above.**

AND, In addition I authorize the following adults & step-parents to make such medical treatment decisions as listed above, in my absence:

Name **Relationship** **Phone**

Authorization Signature **Date**

Parent/Legal Guardian Full Name **Date of Birth**

This is a legal document, This form shall be presented to a physician or appropriate hospital representative at such time a medical, hospital, or immunization care may be required. (Legal Guardianship requires written proof).