Medical Consent Authorization for Minor Patients

Medical Arts Allergy, P.C.

☐ I, _____ am the parent of the child(ren) listed below and there are no court
(Parent's Name)
orders now in effect that would prohibit me from conferring the power to consent upon another person.

☐ I, _____ am the legal guardian or legal custodian of the child(ren) by court order
(Name of Legal Guardian or Legal Custodian)
(copy attached, if available) and there are no other court orders in effect that would prohibit me from conferring the power to consent upon another person.

I, _____ do herby confer upon
(Name of Parent or Legal Guardian or Custodian)

1. _____
2. _____
3. _____

(Name of Person(s) Bringing Child(ren) for Care)

the power to consent to necessary medical treatment for the following child(ren):

1. _____Date of Birth_____
2. _____Date of Birth_____
3. _____Date of Birth_____

Residing at: _____

and on the child(ren)'s behalf do hereby state that the power to consent that I confer shall not be affected by my subsequent disability or incapacity.

The power that I confer is specifically limited to health care and mental health care decision making, and it may be exercised only by the person named above.

The person named above may consent to the following examinations/treatments by Medical Arts Allergy, P.C. for my child(ren): (**check all that apply**)

☐ Allergy Injections ☐ Emergency Treatment ☐_____
(Other treatment Child(ren) May Receive)

and may have access to any and all records, including, but not limited to, insurance records regarding any such services.

I confer the power to consent freely and knowingly in order to provide for the child(ren) and not as a result or pressure, threats or payments by any person or agency. This document shall remain in effect until it is revoked by my written notification to my child(ren)'s medical, insurance providers, and the person named above.

Emergency Contact:_____ _____ _____

_____ _____ _____

(Names) (Phone Numbers)

In witness whereof, I have signed my name to this medical consent authorization, on this _____ day of _____, 20_____, in _____, Pennsylvania.

_____ (Printed Name) _____ (Signature)

_____ (Witness)