# MEDICAL TREATMENT AUTHORIZATION FORM

This form grants temporary authority to a designated adult to provide and arrange for medical visit for a minor, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them or have them accompany the minor to the physician's office. **This form must accompany minor to visit.**

## MINOR

Full Legal Name: _____ Date of Birth: _____/_____/_____

Home Address: _____

## INFORMATION FOR MEDICAL TREATMENT

Practice Name and Location: **The Kids Clinic, 12317 15th Ave NE, Ste 103, Seattle WA 98125**
**206-957-1881**

## TREATMENT

Explicitly identify **what conditions child can be treated for during visit**:

_____

## AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for:

Name: _____ Driver License Number: _____

to transport and accompany Minor to the Physician office for the Treatment. I agree to assume financial responsibility for all expenses of such care. **I agree to be available during the scheduled physician's visit at the phone number on file at the physician's office.**

This authorization is effective on date: _____/_____/_____ (not valid for more than 1 day)

Parent / Legal Guardian Signature: _____

Parent / Legal Guardian Printed Name: _____