HERITAGE PEDIATRICS
Caring for the Next Generation

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Advance Consent to Treat Minors

Patient Name_____DOB_____

The undersigned hereby authorizes the following person(s) as our agent to give consent to surgical or medical treatment by any licensed physician, provider or nurse at Heritage Pediatrics for the above named minor child. Such treatment is deemed necessary by the physician, and I cannot be reached within a reasonable time, by reason of absence from the community or otherwise. Such consent may include, but is not limited to, administration of necessary anesthetics, medical treatment, tests, X-ray examinations, transfusions, injections or drugs and the performing of whatever procedures may be deemed necessary or advisable.

Please list any other agents to act on your behalf (grandparents, nannies, close friends, etc.):

_____

Name Phone Number

_____

Name Phone Number

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide the authority to consent thereto as our said agent and the above-named child's attending physician, in the exercise of his best judgment, may deem advisable.

This authorization shall remain effective unless revoked in writing by the undersigned.

_____

Signature of parent/legal guardian Date