PEAK PEDIATRICS

Consent to Treat Patient by Non-Parent/Legal Guardian

I, _____ (full legal name), am the parent or legal guardian of the minor child(ren) named below:

Name of child (full legal name)	Date of birth	Relationship to child

I hereby authorize the following person (must be age 18 or older) to act on my behalf for my child(ren)'s medical care:

Full Legal Name _____ Relationship to Patient _____

This includes the following:

☐ Authorization for decision making for any and all medical, dental, and mental health care for the well-being of my minor children which includes, but is not limited to: medical and dental exams, tests, x-rays and radiological procedures, surgeries, anesthesia, hospital care, and mental health care including medication and treatment.

OR

☐ Authorization to bring my children to scheduled routine well-child and sick visit appointments and receive routine treatment, medications, and immunizations as recommended by my child's medical provider.

Special power of attorney shall be in effect until _____ unless revoked in writing earlier by the parent or guardian. In any case, the authority granted herein shall not be valid for more than 12 months from the date of this document.

Signature _____ Date _____