

## Authorization for Treatment of Minor Lacking Capacity to Consent

This will authorize \_\_\_\_\_ and other physicians under his/her supervision to provide medical care, including examination, treatment, X-ray examination, laboratory tests, local anesthetics, medical diagnosis and hospital care to \_\_\_\_\_, a minor (DOB \_\_\_\_\_).

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospitalization in order to avoid delay in providing such treatment as is deemed necessary by the aforementioned doctor(s).

This authorization to treat will remain in effect until \_\_\_\_\_, 20\_\_\_\_, unless revoked sooner in writing.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian/Person having legal custody

\_\_\_\_\_  
Print Name of Parent/Legal Guardian/Person having legal custody

\_\_\_\_\_  
If signed by other than parent, indicate relationship

- This form authorizes said minor to present for minor care and treatment unaccompanied by an adult.
- This form authorizes said minor to present for minor care and treatment accompanied by an adult other than his/her parent or legal guardian.
- Copy to parent or legal guardian.**

