Town Pediatrics, PC

Patricia F. Rappaport, MD, FAAP
Sandra J. Groeber, MD, FAAP
Nancy Tang, MD, FAAP
Azza H. Idris, MD, PhD, FAAP
Janine A. Rethy, MD, MPH, FAAP, IBCLC

Medical Authorization for Minors

I, ____________________________, the parent or legal guardian of the below mentioned minor child(ren), do hereby grant my authorize and consent to seek medical care to any one or more of the below mentioned adults whose care the minor child(ren) has been entrusted to act as agent(s) for myself in my absence. Medical care includes, but is not limited to, any treatment of illnesses, disease, well care, immunizations and medical advice.

CHILD (Please Print)	DATE OF BIRTH

AGENT NAME	RELATIONSHIP	ADDRESS	PHONE#

It is understood that the authorization is given in advance of any specific diagnosis, treatment or care being required but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which a physician or healthcare provider in the exercise of his or her best judgment may deem advisable.

This authorization shall remain in effect until ____________________ or until the child(ren) reach 18 years of age.

Signature of Parent/Legal Guardian ____

Printed Name______________________________ **Date**___/ ___/____