Advance Consent to Treat Minors

The undersigned hereby authorizes the individuals named below as my/our agent in my/our absence to give consent to both routine and emergency surgical or medical treatment by any licensed physician, physician's assistant, or nurse practitioner in the employ, or acting on behalf, of ***Pacific Crest Family Medicine*** for ____________________, my minor child. Such consent may include, but is not limited to, administration of necessary anesthetics, medical treatment, tests, X-ray examinations, transfusions, injections (including immunizations) or drugs and the performance of whatever procedures may be deemed necessary or advisable. In such case of my/our absence the individuals identified below are granted complete authority to act in my/our stead, including the assumption by me/us of any financial obligations created thereby.

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 or her best judgment, may deem advisable.

Authorized Individuals

PLEASE NOTE: Authorized Individuals must be at least 18 years of age. Photo ID may be required.

Name	Relationship to patient

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

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Signature of parent/legal guardian Date

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Signature of parent/legal guardian Date