South River Pediatrics

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

Under law, the physicians of South River Pediatrics need permission to treat your child in your absence. If there should ever be the possibility of someone other than yourself, the custodial parent, bringing your child in for treatment, whether it is for a well visit or when he or she is sick, please complete the information below so that we may treat your child. This form authorizes these persons to sign the consent for vaccine administration and to agree to any health care the child should need.

Payment of any co pays, coinsurance, or charges for services rendered in the case of no insurance are due at the time of treatment and will be the responsibilty of the adult bringing the patient in for care.

I,_____, am the custodial parent having legal custody of _____ _____, a minor child, born on _____
I authorize the people listed below to do any acts which may be necessary or proper for the health care of the minor child, including, but not limited to, the power to provide for such health care at South River Pediatrics by the physicians, nurses, or other persons whose services may be needed for such health care, and to consent to and authorize any health care, including administration of vaccines, medications, and other procedures, except the withholding or withdrawl of life- sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing. By signing here, I indicate that I have the understanding and capacity to recognize the importance of, to communicate, and to assign the health care decisions covered by this document, I am fully informed as to the contents of this document, and I understand the full scope and importance of powers to the agent(s) named herein.

_____

(Custodial Parent's Signature) **(Date)**