Your family matters

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North Seattle Pediatrics
Advance Consent to Treat Minors

Patient Name:_____ Date of Birth:_____

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The undersigned hereby authorize

(person other than parent) _____
name(s) of person bringing child

_____

_____

_____

Relationship to patient_____
Grandparent, nanny, aunt, etc.

The above person is designated as our agent to give consent (verbal or written) to surgical or medical treatment by any licensed physician or provider at North Seattle Pediatrics for my minor child. Such treatment is deemed necessary by such physician and I cannot be reached within a reasonable time, by reason of absence from the community or otherwise. Such consent may include but is not limited to, administration of necessary anesthetics, medical treatment, test, X-ray examinations, transfusions, injections, immunizations or drugs and the performing of whatever procedures may be deemed necessary or advisable.

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 judgement, may deem advisable.

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

_____

Signature of parent/legal guardian Date