

## AUTHORIZATION FOR TREATMENT OF MINOR

*(To be used when a previously established teenage patient comes to the office unaccompanied.)*

I, the undersigned parent or legal guardian, of \_\_\_\_\_, a minor, do hereby consent for Terence A. Degan, MD to provide routine medical care to him/her. This includes immunizations, examination with chaperone, treatment such as local anesthesia, minor surgery, prescriptions and the completion of school forms or sports physicals. (In the case of a sports physical, I agree to notify Dr. Degan if there is any family history of passing-out or sudden death.) I understand that this authorization is given in advance of any specific diagnosis. I also understand that Dr. Degan - before any care at all is provided - may request another visit with myself in attendance if he determines that the complexity or seriousness of the presenting complaint warrants a specific consent or further discussion.

My specific request or concern for today is:

\_\_\_\_\_  
\_\_\_\_\_.

I certify that he or she is allergic only to: \_\_\_\_\_.

This authorization remains in effect until \_\_\_\_\_ 200\_\_, unless revoked sooner in writing.

Dated: \_\_\_\_\_ 200\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship: \_\_\_\_\_