AIRWAY PEDIATRICS

TREATING MINORS WITHOUT A PARENT OR LEGAL GUARDIAN

Patient Name: _____ Patients DOB: _____

Patient Name: _____ Patients DOB: _____

Patient Name: _____ Patients DOB: _____

Patient Name: _____ Patients DOB: _____

Patient Name: _____ Patients DOB: _____

Patient Name: _____ Patients DOB: _____

I, _____ (parent / legal guardian), authorize treatment of the minor patients when accompanied by the following decision-making persons at their appointments:

Name	Date of Birth	Relationship to Child	Phone Number

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

Parent or Legal Guardian's Printed Name _____

Parent or Legal Guardian Signature _____ Date _____