Suggested Formats for Advance Consent to Treat Minors

I,_____, the parent or legal guardian of my child,_____, authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel of Northwest Pediatric Ophthalmology. This authorization will be in effect until revoked in writing by me.

_____

Signature of parent/legal guardian Date

Please list name of individuals you authorize to seek medical services for your child on your behalf:

_____	_____
(Name)	(Relationship to patient)
_____	_____
(Name)	(Relationship to patient)
_____	_____
(Name)	(Relationship to patient)
_____	_____
(Name)	(Relationship to patient)
_____	_____
(Name)	(Relationship to patient)
_____	_____
(Name)	(Relationship to patient)