Authorization For Evaluation And/Or Treatment of A Minor Child Unaccompanied By Parent or Legal Guardian

A parent or legal guardian must accompany a child younger than 18 years of age to consent for all medical and/or surgical treatment provided by Acorn Pediatrics. Please complete this form if your child(ren) will be coming for a visit, treatment, or procedure without a parent or legal guardian. This consent is valid for the time specified with a **maximum of one year** from the date signed.

I, _____, custodial parent or legal guardian of the listed child(ren):

Name of Child	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

do hereby authorize the persons listed below to give consent to medical treatment including administration of immunizations by Acorn Pediatrics for my child(ren). These authorized adults may also receive test results and additional information pertinent to the care and treatment of the child(ren).

Name of person being authorized	Relationship to patient
_____	_____
_____	_____
_____	_____

This written consent is valid for the time period: _____ to _____. (Not to exceed one year) at which time a new consent form will be required. This consent may be revoked by me at any time in writing.

_____

Custodial Parent/Legal Guardian Date Signed