NORTH POINT PHYSICIANS LLC

CONSENT TO TREAT A MINOR CHILD
IN THE ABSENCE OF A PARENT OR GUARDIAN

I hereby authorize the providers (Physicians, Nurse Practitioners, Medical Assistants) of North Point Physicians, LLC, to treat my minor child in my absence. This treatment may include, but is not limited to: Routine Evaluation and Management Services, In-Office Diagnostic Laboratory Procedures (i.e. Strep Tests, Cultures, Urinalysis), Immunizations, Vaccinations, Injections, Minor In-Office Procedures (i.e. Splinter Removal, Foreign Body Removal, Incise and Drain), Fracture Care, Wound Care, Suture and /or Wound Closure. I understand that some procedures may require additional consent forms to be signed and that I may be required to submit them in advance of a scheduled procedure.

I understand that my absence does not relieve me of any obligation or responsibility that I would normally bear while present.

This authorization is effective from: _____ to: _____.

I understand that I may terminate this authorization by providing written notice in advance of any scheduled appointment.

Child's Name: _____

Child's Date of Birth: _____

Parent/ Guardian Signature: _____

Date: _____

Parent/ Guardian Name (Print): _____

Relationship to Child: _____

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