Ballard Pediatric Clinic

Advance Consent to Treat Minors In Absence of Parent / Guardian

Phone: 206-783-9300 / Fax: 206-315-8848

Patient Name:________________________________**Date of birth:**_________________

Patient Name:________________________________**Date of birth:**_________________

Patient Name:________________________________**Date of birth:**_________________

Patient Name:________________________________**Date of birth:**_________________

The undersigned hereby authorize: ____
Print name of person bringing child (not parent/guardian)

Relationship to patient: ____
Grandparent, nanny, etc.

The above person is designated as our agent to give consent (verbal or written) to surgical or medical treatment by any licensed physician or provider at Ballard Pediatric Clinic for my minor child. Such treatment is deemed necessary by such physician and I cannot be reached within a reasonable time, by reason of absence from the community or otherwise. Such consent may include, but is not limited to, administration of necessary anesthetics, medical treatment, tests, X-ray examinations, transfusions, injections, immunizations or drugs and the performing of whatever procedures may be deemed necessary or advisable. Further, consent is granted to said physician to exercise his or her discretion in authorizing the disposal of any severed tissue or members.

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.

____ ______________________
Signature of parent/legal guardian Date