CORE PHYSICIANS
an exeter health resource | The Art of Wellness

Authorization to Treat a Minor When Unaccompanied by a Parent or Legal Guardian

Name of Parent / Legal Guardian: _____

Name of Minor: _____ Date of Birth: _____

I am the parent or legal guardian having legal custody of the above-named minor. I understand that a parent or legal guardian is the only person authorized to consent to the treatment of a minor.

I will make every effort to accompany the minor to Core Physicians for his/her routine office visits. However, in the event that I am unable to accompany the minor, I agree to the following (as indicated by my initials):

(*Write your initials next to each item for which you give permission)*

_____ **UNACCOMPANIED MINORS**

If I (or the minor's other parent or legal guardian) cannot accompany the minor for his/her routine office visits, and if the minor is at least 16 years old, I request and authorize the physicians and other clinical personnel at Core Physicians to evaluate and perform routine medical treatment for the minor, even if the minor presents to Core Physicians unaccompanied by a parent, legal guardian or other adult.

_____ **MINORS ACCOMPANIED BY AN ADULT OTHER THAN A PARENT OR LEGAL GUARDIAN**

If I (or the minor's other parent or legal guardian) cannot accompany the minor for his/her routine office visits, I request and authorize my designated representative (named below) to consent to the evaluation of and routine medical treatment of the minor by the physicians and other clinical personnel at Core Physicians. I understand that it is my responsibility to give written notification to Core Physicians if the name of my designated representative changes.

_____
Name of Designated Representative

_____ **IMMUNIZATIONS**

I understand that, in order to receive routine immunizations, the minor, regardless of age, must be accompanied by either a parent, legal guardian, or an adult representative designated by a parent or legal guardian.

If I cannot accompany the minor for his/her routine immunizations, I request and authorize my designated representative (named below) to review information about and to consent to regularly scheduled vaccinations for the minor. I understand that it is my responsibility to give written notification to Core Physicians if the name of my designated representative changes.

In addition, I understand that I must send a signed and dated note with my designated representative that specifies that the representative can review information about and consent to regularly scheduled vaccinations, and that specifies the dates for which the authorization is effective.

_____
Name of Designated Representative

I acknowledge that I have read and understand the above statements.

_____ _____
Signature of Parent or Legal Guardian Date