

RALEIGH PEDIATRIC ASSOCIATES, PA

Patient's Name: _____ Date of Birth: _____ Chart#: _____

Parental Authorization to treat Minor Child when not accompanied by Parent or Guardian

(This authorization is for patients under 18 years of age.)

We must have permission from a child's parent or guardian before providing medical services when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. If you feel there may be an occasion where your child will be brought by a relative, sitter, etc., please fill out the following information for us to include with your child's records.

The following person(s) have my permission to authorize medical care for my child and sign any necessary waivers on my behalf.

Name	Relationship		Name	Relationship

For patients 16 years and older ONLY:

Yes ___ No ___ patient listed above may present and be treated unaccompanied by an adult.

Signature of Parent
or Legal Guardian _____ Date _____