Boulder Medical Center

Chart #
(For internal use only)

Authorization Consent to the Treatment of a Minor

Name of Child:_____ Child Date of Birth: _____

The purpose of this form is to give designated agent(s) the power and authority to consent to medical treatment for my child.

_____ I hereby authorize and appoint the individual(s) listed below as my agents:
Initials

1. _____

2. _____

3. _____

My agents may consent to any necessary treatment for my child **unless specified here**:

_____

_____

It may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present during treatment.

_____ I hereby authorize Boulder Medical Center, P.C. to deliver medical care to my child without a
Initials parent/guardian being present.

Any necessary treatment may be delivered **unless specified here**:

_____

I hereby authorize the administration of any age-appropriate vaccines: ☐ Yes ☐ No
This power and authority will be effective as of _____/____/_____
This consent will remain in effect until it is revoked by notifying the medical facility in writing.

By signing this form, I confirm that I am the parent/legal guardian of the minor listed above and there are no court orders in effect that would prohibit me from conferring the power to consent upon another person. I hereby authorize and appoint the individual(s) listed above, the power and authority to consent to medical treatment for my child.

Parent/Legal Guardian Name: _____
Please Print

Relationship: _____**Parent/Legal Guardian Phone Number**: _____

Parent/Legal Guardian Signature: _____

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