ACCESA HEALTH

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Authorization to Treat a Minor

I _____ (parent's name) hereby authorize the following person to give their consent for health care treatment to be administered by medical providers at Accesa Health to my minor child _____ (minor's name) until _____ (date you wish this authorization to expire, state "no expiration" if desired).

Representative: _____ Relationship: _____

I am aware that Accesa Health medical providers diagnose and treat common illnesses, prescribe medications, recommend over the counter medications, provide health screening and diagnostic testing and administer vaccinations, among other services.

I have listed any known allergies my child has in the space below.

Known Allergies (including medications, dye, latex, eggs, etc.)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Signature of Parent: _____

Relationship to Minor: _____

Date: _____