Harnett Health

PLEASE READ CAREFULLY:

Under law, the providers of Harnett Health physician practices need your permission to treat your child in your absence. If there should ever be the possibility of someone other than yourself (the legal custodial parent or guardian) bringing your child in to our office for treatment, whether it is for a well visit or when the child is sick, please complete the information below so that we may treat your child. This form authorizes these persons to sign consent for vaccine administrations and agree to any healthcare the child should need in your absence.

Payment of any co-pays, coinsurance, or in the case of no insurance any other charges for services rendered are due at the time of treatment and will be the responsibility of the adult bringing the child in for medical treatment.

I, _____, am the custodial parent having legal custody of _____, a minor child, date of birth _____.

I authorize the people listed below to do any acts which may be necessary or proper for the healthcare of the minor child, including but not limited to the power to provide for such healthcare at Harnett Health physician practices by the medical providers, nurses, laboratory personnel, or other persons whose services may be needed for such healthcare, and to consent to and authorize any healthcare, including administration of vaccines, medications, and other procedures, except withholding or withdrawal of life-sustaining procedures.

This consent shall be effective from the date it is executed until the date I terminate it in writing that is witnessed by this healthcare provider office. By signing this form, I indicate that I have the understanding and capacity to recognize the importance of and to communicate and assign the healthcare decisions covered by this document, and I am fully informed as to the contents of this document. I understand the full scope and importance of powers to the agent/persons named herein.

(Legal Custodial Parent / Guardian Signature) (Date)

Witness by Harnett Health Staff _____ Date_____

Name of Person(s) Authorized to Bring Child for Medical Treatment	**Relationship to Child / Phone number**