



**PLEASE READ CAREFULLY:**

Under law, the providers of Premiere Pediatrics 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 health care 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 health care of the minor child, including but not limited to the power to provide for such health care at Premiere Pediatrics of Harnett Health by the medical providers, nurses, laboratory personnel, or other persons whose services may be needed for such health care, and to consent to and authorize any health care, 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 health care 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 Premiere Pediatrics Staff** \_\_\_\_\_ **Date** \_\_\_\_\_

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