Unattended Minor Consect Form

Patient name:__________________________________ D.O.B.____________

If I am unable to be present, I hereby give Northern Lights Pediatric & Adolescent Medicine permission to treat as deemed medically necessary, by a physician or nurse practioner. Furthermore, in my absence I authorize the following person(s) to seek medical attention for my child from Northern Lights Pediatric & Adolescent Medicine.

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Parent/Legal Guardian signature ____________________________________

Date:_______________ Daytime phone number:______________________

(consent valid for 1 year)

The following person(s) *DO NOT* have authorization to accompany my child to appointments at Northern Lights Pediatric & Adolescent Medicine.

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