TOWN & COUNTRY
Family Physicians
Anthony J. Popek, MD Laurel M. Tucker, MD Henry C. Jackson, MD
Lubna Momin, NP-C Shannon Borden, NP-C
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CONSENT TO TREATMENT OF CHILD/MINOR BY A NON-PARENT/LEGAL GUARDIAN

This form grants temporary authority to a designated provider to provide and arrange for medical treatment for a minor in the event when the minor is not accompanied by either parents or legal guardians. This form is intended to be utilized when the parent or legal guardian is unavailable.

Minor Full Legal Name: ____

Date of Birth: ____________________________ Gender: Female__________ Male__________

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I, ______________________________ (name of parent/legal guardian), do hereby state that I have legal custody of the aforementioned Minor and the authority to authorize someone other than myself to consent on my behalf. I grant my authorization and consent for provider:

Please check the name of the Provider your child/minor is seeing today.

☐ Anthony Popek, MD

☐ Laurel Tucker, MD

☐ Henry Jackson MD

☐ Lubna Momin, NP-C

☐ Shannon Borden, NP-C

To administer medical treatment for any minor injuries or illnesses experienced by the above referenced minor. It is understood that this authorization is given in advance of any such medical treatment. **This form is valid for a one-time office visit only. It will expire once services have been rendered to the child/minor.**

Signed this ____ day of _______________________, 20____.

Parent / Legal Guardian Signature: __________________________ Printed Name: _______________________

Witness Signature: ____________________________________ Printed Name: _______________________