Authorization to Treat

I __________________________ (print name) hereby authorize the following person (s) to give their consent for health care treatment to be administered by nurse practitioners or physicians assistants at MinuteClinic to my minor child __________________________ (minor’s name) until ________________________ (date you wish this authorization to expire, state “no expiration” if desired).

1. ______________________________   relationship ________________________
2. ______________________________   relationship ________________________
3. ______________________________   relationship ________________________
4. ______________________________   relationship ________________________

I am aware that MinuteClinic nurse practitioners and physician assistants diagnose and treat common viral and bacterial illnesses, prescribe medications, recommend over the counter medications, provide health screening and diagnostic testing and administer vaccinations. I have listed any allergies my child has in the space below.

Known Allergies (including medication, dye, latex, etc.)

(List below, if any):

1. ______________________________
2. ______________________________

Signature: _________________________________   Relationship to Minor: ______________
Date: __________________\n