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: _____