

Children's Clinic of South Snohomish County
Authorization to seek Medical Care

Date: _____

I, _____, the parent/legal guardian of

authorize _____ to seek medical attention for my

child from _____ to _____. I also consent to

Starting date

Ending date

any medical treatment or procedures, to be performed for my child by a licensed physician, that are necessary or advisable in the interest of my child's well being.

This form is valid for a maximum of one year. It is the parents' responsibility to notify Children's Clinic of any changes that might apply.

Under the circumstances set forth above, I elect not to be informed in advance of the nature and character of the propose treatment, its results, possible alternatives, and the risks, complications, and anticipated benefits involved in the proposed treatment, and the alternative forms of treatment, including non-treatment.

Printed name of parent//legal guardian

Signature of parent/legal guardian