OLSON
PEDIATRIC
CLINIC

Authorization to treat in the absence of parent or guardian

I authorize the following person(s) to be present and to give consent for treatment by any provider at the Olson Pediatric Clinic.

_____ _____

Name Relationship

_____ _____

Name Relationship

This authorization is for the following children/child,

First Name	Last Name	Date of Birth
First Name	Last Name	Date of Birth
First Name	Last Name	Date of Birth

_____

Signature of Parent or Guardian

_____

Address

_____

Phone Date

This authorization is effective until _____

PRINT EMAIL