The Kidz Docs
Pediatric & Adolescent Medicine

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Authorization for Treatment and/or Immunization of Minors
In Absence of Parent or Guardian

Today's Date________________________

Patients' Names: Date of Birth:

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My child is 16 years of age (or older). I hereby give The Kidz Docs authorization to treat my child in my absence for:

_____sick visits

_____well checkups

_____vaccine administration

_____PPD (tuberculosis skin test) administration and interpretation

I understand that my child needs to provide proper identification (driver's license, learners permit, school ID card) at the time of the visit. My child will NOT be seen without proper Identification.

If a provider needs to call me while my child is being seen you can contact me at:

Phone number:____

This form remains in full effect until rescinded in writing by parent or legal guardian.

Parent/Legal Guardian Signature____

Parent Legal Guardian Name____