Family Practice Physicians
10301 GLACIER HIGHWAY • JUNEAU, ALASKA 99801
(907) 789-2910

ABBEY CUMMINGS, P.A.-C.
LAURA DOOLEY, M.D.
NATE HADDOCK, M.D.
ALEX MALTER, M.D.
WENDY SMITH, P.A.-C.
NANDI THAN, M.D.

Consent to Treat Patient-Without Parent/Legal Guardian Present

Authorization:

I have the legal right to preauthorize Family Practice Physicians and its personnel to deliver routine medical treatment and services to my child. Routine Medical care and interventions may include, but are not limited to: medical evaluation, physical exam, routine immunizations, injections, x-rays, lab work (examples: throat or nasal swabs, blood draws, wart treatment, minor burns, minor suturing of lacerations)

I ________________________ request and authorize Family Practice Physicians and its personnel to deliver routine medical care to my child listed below as may be deemed necessary or advisable in the diagnosis and treatment of the minor child:

Child's Name: ________________________________ DOB: ________________________
Allergies: ____
Current Medications: ____
Chronic Conditions: ____

Limitations:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, state "none")

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Parental contact information for questions regarding treatment of the child:
Parents name: ____
Contact info: (c)________________(h)__________________(w)___________________
Address: _______________________________City__________State_________Zip_____

I understand and agree that the signatures and dates on this form will not expire without written notice or in case that a minor becomes the age 18, and that a photocopy of this form is considered valid as the original.

____   ________________
Parent or Legal Guardian (please print) Relationship   Date

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Parent or Legal Guardian (Signature)