



AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

To: **Big Lake Clinic**

Patient Name: _____

Patient Date of Birth: ____/____/____

I hereby authorize _____ (related to the above-named minor as his/her) to consent to **routine health care**, including immunization procedures and allergy treatments, on the minor's behalf as is necessary for the minor's health and best interests.

I also authorize the above-named person to act on my behalf in case the minor experiences a reaction to the authorized treatments, or is a victim of injury or illness when immediate medical or surgical care is needed, provided diligent efforts are made to notify me of the situation and obtain my preferences. If such efforts to contact me are unsuccessful, I hereby authorize the above-named person to take such actions and give such consent on the minor's behalf, as that person's reasonable judgment dictates.

I understand that this consent will last for one year unless I change my mind and withdraw my consent sooner in writing. If I withdraw consent, it will not affect actions already taken by _____.

Date: ____/____/____

Signature of person who is granting authority to consent: _____

Relationship to named minor: _____