KJARTAN D. ARMANN, M.D.
Infant, Child and Adolescent Medicine

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MEDICAL TREATMENT AUTHORIZATION AND CONSENT FORM

This form is designed to allow parent(s) or legal guardians to designate another adult to arrange for temporary medical care for the child. It's important that, medical care can not be provided to a minor without approval by the parent(s) or legal guardians, unless there is written consent authorizing another adult to bring their child in at the time of the appointment.

Child's Name: _____

Child's Date of Birth: _____

Name of Adult Designee: _____

Relationship to Patient: _____

The above named person has my permission to bring my child to his/her appointment(s) and I authorize Kjartan D. Armann, M.D. to perform on my child any necessary or routine medical treatment, including examination, injection and immunizations. I understand that in unusual circumstances efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached.

This authorization will remain effect unless parent(s) or legal guardians rescind this consent.

Signature: _____Date: _____

Name: _____

☐ Mother ☐ Father ☐ Legal Guardian