Facey
Medical Group

Temporary Authorization
For Consent to Treat a Minor

I am aware that my child may require treatment when I am not able to be present. In my absence, I give

1. _____ Relationship: _____

2. _____ Relationship: _____

3. _____ Relationship: _____

my permission to authorize medical treatment for my child, _____
Print Name

-OR-

In my absence, I give permission to a Facey Medical Group provider to provide care and treatment to my child, _____
Print Name

In addition, the provider has my permission to refer my child's emergent care to the appropriate service physician to provide optimal care for the treatment of illness or injury.

This authorization is valid until it is revoked in writing.

Print Parent/Legal Representative's Name	Relationship to Patient	Date/Time
Parent/Legal Representative's Signature	Witness to Signature	Date/Time

Patient Name	Medical Record #	
Patient Date of Birth	Patient Telephone#	
Dr. Name	Dr #	Loc.
Appointment Date		
Insurance Coverage		
Insurance Co-Pay		

SCAN under Consent*

FMF – 013, Rev 03/12, Tara Safeguard LITHO USA Form No. 811-2/Y12CS000557 12/12

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Immunization Consent Form

Facey follows national immunization guidelines set by the American Academy of Pediatrics (AAP), the Centers for Disease Control (CDC) and the Immunization Action Coalition (IAC). Your child will be immunized at established intervals throughout their infancy and childhood.

I /We authorize Facey Medical Group to give immunizations in accordance with the scheduling guidelines of the aforementioned organizations.

Child's Name: _____ Date of Birth:_____

Parent/Guardian's Name (Print):_____

Parent/Guardian's Signature: _____

Date: _____

Patient Name	Medical Record #	
Patient Date of Birth	Patient Telephone #	
Dr. Name	Dr. #	Loc:
Appointment Date		
Insurance Coverage		
Insurance Co-Pay		

SCAN under Consent*