

**St. Francis Family Health Care**  
**Authorization to Consent to Medical Treatment of a Minor Child**

- As parent or legal guardian of \_\_\_\_\_, by \_\_\_\_\_, by  
(name of child) (date of birth)  
this document I authorize the following individuals to consent to medical treatment provided by the physicians and staff of St. Francis Family Health Care for the said child in absence of parent or legal guardian.

\_\_\_\_\_  
(name of responsible adult) (relationship to child)

\_\_\_\_\_  
(name of responsible adult) (relationship to child)

\_\_\_\_\_  
(name of responsible adult) (relationship to child)

- As parent or legal guardian of \_\_\_\_\_, by \_\_\_\_\_, by  
(name of child) (date of birth)  
this document I authorize that the said child is between the ages of 16-18 years old and may be treated by the physicians and staff of St. Francis Family Health Care without the presence of a parent or legal guardian.

This authorization is to remain in effect:

- for one year after the signing date of the parent or legal guardian.  
 until revoked in writing by parent or legal guardian.  
 other \_\_\_\_\_.

\_\_\_\_\_  
(printed name of parent or legal guardian) (signed name of parent or legal guardian) (date)

\_\_\_\_\_  
(printed name of parent or legal guardian) (signed name of parent or legal guardian) (date)