Virginia Pediatric and Adolescent Medicine, PLC
5275 Lee Highway, Suite 200
Arlington, VA 22207
Tel: (703) 717 4090 Fax: (703) 717-4091

Medical Authorization for Minors

I, _____ , the parent or legal guardian of the below mentioned minor child(ren), do hereby grant my authority and do consent to seek medical care to any one or more of the below mentioned adults whose care the minor child(ren) has been entrusted to act as agent(s) for myself in my absence. Medical care includes, but is not limited to, any treatment of illnesses, diseases, well care, immunizations and medical advice.

Child	Date of Birth

Agent's Name	Relationship	Phone #

Address	City	State	Zip

It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required but is given to provide authority and power on the part of the aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which a physician or healthcare provider in the exercise of his or her best judgment may deem advisable.

This authorization shall remain in effect until _____
or until the child(ren) reach 18 years of age.

Signature of Parent or Legal Guardian:

Printed Name: _____

Date: _____