EXHIBIT A

MINOR DELEGATION TREATMENT FORM

I, _____, of city
(Name)

_____, county _____ state _____, do hereby state that I am

the parent or legal guardian of _____,
(Name)

a minor, born _____ who resides with me at

_____.
(Street Address) (City) (State)

I authorize the following individuals to bring said minor to medical appointments within the Pediatric Department and consent to the following:

	Name	Relationship	Phone Number
1.			
2.			
3.			
4.			
5.			
6.			

☐ Immunizations

☐ Well-child care visits

☐ Any necessary examination, anesthetic, medical diagnosis, surgery, treatment, and/or hospital care to be rendered to the above-named minor under the general or direct supervision and on the advice of any physician or surgeon licensed to practice medicine in the state(s) where the care is to be provided.

This consent will expire one year from the date this form is signed, unless otherwise specified below. The consent may be revoked, in writing, by the legal guardian at any time.

Signature of parent or legal guardian _____

Printed name of parent or legal guardian _____

I consent to the use of this form for the following dates_____

Signature of adult witness _____

Date signed _____