ORTH RALEIGH FAMILY MEDICINE
8331 Bandford Way, Suite 101 ◆ Raleigh, NC 27615
(919) 841-4566 ◆ Fax: (919) 841-4568

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

I, _____, of _____ County, ___NC_____State, am the
Print Your Name

custodial parent/guardian having legal custody of _____,
(Name of Minor)

In my absence the following person(s)* may do any acts which might be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of minor operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

Names of Authorized Persons: (Include the minor if they are driving and have permission to arrive alone for their appointments)

_____ Print Name	_____ Relationship to Minor
_____ Print Name	_____ Relationship to Minor
_____ Print Name	_____ Relationship to Minor

This consent shall be effective from the date of my signature below until _____.

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By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

_____ Print Name of Parent/Guardian	_____ Signature of Parent/Guardian	_____ Date
_____ Print Name of Witness	_____ Signature of Witness	_____ Date

***Persons to whom authority to consent to treatment of minors must be 18 years of age or older or an emancipated minor. The witness may not be the person designated by the parent/guardian to consent to healthcare for the minor.**