Alaska Urgent Care

AUTHORIZATION TO TREAT MINOR

Patient's Name _____ DOB: ____/____/____

Name of Child/Minor _____

As the parent/guardian of the above-named child/minor, I hereby give permission to healthcare providers of Alaska Urgent Care to examine the child/minor in the event that a medical issue arises and I am unable to personally consent to the treatment. I also agree to be responsible to the clinic and all other ancillary service providers for charges incurred relating to medical services rendered.

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

Parent/Guardian Home Address _____

Work Phone _____ Home Phone _____

Employer _____

Alternate Emergency Contact _____

Chronic Illnesses or Allergies _____

_____

_____

Medications _____

Private Physician _____ Phone _____

Health Insurance Company _____

Policy Number _____ Member Number _____