Care of a Minor Child Waiver

I, _____ being the parent or legal guardian of _____

authorize _____ to attend with my child their appointment with the provider at Painted Rock Family Medicine. By signing below, I authorize the aforementioned person to make medically relevant decisions regarding my minor child. This includes any decisions regarding medications, blood work, imaging, and any other decision involved in my child's care.

Please check one:

____ I authorize this person to bring my child in on this date: _____

____ I authorize this person to bring my child in on any date until the expiration of this waiver on this date:_____ (date should not exceed 1 year from today's date).

Signature:_____ Date:_____

Print Name:_____

Child's Date of Birth:_____

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