Terry C. Childers, **MD, FAAP**
Kiersten S. Derby, **MD, MPH, FAAP**
Margaret E. Goodwin, **MD, FAAP**

MOUNTAIN AREA
PEDIATRICS

Mark T. Jackson, **MD, FAAP**
Brian P. O'Donnell, **MD, FAAP**
Karen J. Walter, **MD, FAAP**

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MEDICAL CONSENT FOR MINOR CHILD

I, _____, the parent or legal guardian of

_____, DOB _____ do hereby consent and allow the following individuals to make medical care decisions for my child including but not limited to the administration of vaccines, labs, blood work or any other care recommended or deemed necessary for the welfare of my child determined by a physician.

_____

_____

_____

_____

This authorization is effective on this _____ day of _____, 20____ and will expire 366 days from this date.

Parent signature:

_____ Date: _____