AUTHORIZATION FOR TREATMENT WHEN PARENT/GUARDIAN IS NOT PRESENT WITH CHILD **(Nanny, Grandparent, Step-Parent, and/or teen by themselves)**

I _____ (Please Print), do hereby consent and authorize Total Access Pediatric Urgent Care LLC and its Providers and Staff to examine and/or treat my child in my absence. I affirm that I have the legal right to consent to this. I understand that this consent is legal and binding until specifically revoked by myself or another person who has the legal right to sign or revoke this authorization. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of examinations and/or treatments. I understand that I will be contacted for a verbal consent if treatment plan includes vaccines/procedures etc. and the best number to reach me for this is: _____

Print Name _____

Signature _____

Date _____