Arizona & Family Geriatric Medicine

I_____give permission to my child _____ to attend his/her appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Arizona Family & Geriatric Medicine. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance. This authorization is effective on: _____ and expires _____ .

Child Health Information

Current prescribed or over-the-counter medications and dosages:

Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____
Medication: _____ Dosage: _____

Allergies, illness, or other comments: _____
_____

Emergency Contact Information for Parents/Guardians:

Where/How can you be contacted in case of Emergency?

_____

Phone: _____

Comments:

_____

Temporary Guardian Information

Name: _____ Phone: _____

Address:

_____

Health Insurance Information: No change since last visit (skip to next section)

Insurance Company: _____ Policy Holder:

_____

ID Number: _____ Group Number: _____

Effective Date: _____ Copay: _____

Parent or Legal Guardian's Signature: _____

Date: _____