Authorization to Treat a Minor

I authorize One Pediatrics at Simpsonville to treat my child/children in my absence when under the direct supervision of the following named individuals:

1. _____
2. _____
3. _____
4. _____
5. _____

I give the above individual(s) permission to make medical decisions regarding my child and have my child receive treatment under their supervision. I understand that it is office policy NOT to have my child/children receive vaccinations, however, without a parent or legal custodian present. I also understand that it is in my child's best interest to have a parent or legal custodian be present at all well-child visits/physicals to be able to provide my doctor the most up-to-date and accurate information about my child and be involved as much as possible regarding my child's medical care.

Signature _____

Relationship to Patient _____

Date Signed _____

ONE Pediatrics, PLLC: All Star Pediatrics, East Louisville Pediatrics, One Pediatrics at Simpsonville, Prospect Pediatrics, South Louisville Pediatrics, Springs Pediatrics, and Oldham County Pediatrics.