Authorization to Treat in the Absence of Parent or Guardian

I authorize the following person(s):

_____, my _____,

_____, my _____,

_____, my _____,

to be present at any exam and consent to treatment by any provider at The Children's Clinic of Klamath.

This authorization is for my child/children:

First Name	Last Name	Date of Birth
First Name	Last Name	Date of Birth
First Name	Last Name	Date of Birth
First Name	Last Name	Date of Birth
First Name	Last Name	Date of Birth

Parent/Guardian Signature Printed Name

Address

Phone Date

☐ Not applicable at this time _____

Signature Date

2580 Daggett Avenue
Klamath Falls, OR 97601
Tel: 541-884-1224/ Fax: 541-884-1637
www.cckonline.com