AUTHORIZATION FOR TREATMENT OF A MINOR WITHOUT A PARENT OR LEGAL GUARDIAN PRESENT

QUAD CITIES PEDIATRICS, P.C. &
JUST 4 KIDS URGENT CARE
5510 Utica Ridge Road, Suite 100
Davenport, IA 52807
Phone: (563) 424-2025
FAX: (563) 424-2042

This authorization allows Quad Cities Pediatrics, P.C. and Just 4 Kids Urgent Care to provide medical evaluation and treatment to my child when I am not physically present.

Patient Information

Patient Name:

_____

Patient Date of Birth: _____ /_____ /_____

Parent/Legal Guardian Information

Parent/Guardian Name:

_____

Relationship to Patient:
☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

Primary Phone:

_____

Secondary Phone:

_____

Email:

_____

Authorization

I certify that I am the parent or legal guardian of the above-named minor and have the legal authority to consent to medical care.

I authorize Quad Cities Pediatrics, P.C. and Just 4 Kids Urgent Care, including its physicians, nurse practitioners, physician assistants, nurses, and clinical staff, to evaluate, diagnose, and treat my child when I am not physically present.

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This authorization includes medical care that the treating provider determines is medically appropriate during the visit.

Examples include:

- ✓ Physical examinations
- ✓ Sick visits
- ✓ Well-child examinations
- ✓ Routine diagnostic testing
- ✓ Point-of-care laboratory testing
- ✓ Medications administered in the office
- ✓ Routine procedures appropriate for the visit
- ✓ Vaccinations according to the recommended immunization schedule

Emergency Care

If the provider determines that my child requires emergency medical evaluation or treatment beyond the services available in the office, I authorize Quad Cities Pediatrics or Just 4 Kids Urgent Care to arrange appropriate emergency medical care, including contacting Emergency Medical Services (EMS) or transferring my child to the nearest appropriate emergency department.

The practice will make reasonable efforts to contact me as soon as possible.

Communication

I understand that my child may discuss medical history, symptoms, medications, allergies, and treatment recommendations directly with the healthcare provider.

I understand that the healthcare provider may contact me during or after the visit if additional consent or discussion is necessary.

Limitations

This authorization **does not**:

- Transfer legal medical decision-making authority to my child.
- Prevent the provider from contacting me before providing treatment if additional consent is needed.
- Require the provider to perform treatment they believe is not medically appropriate.
- Require the provider to provide treatment that is prohibited by law or outside the scope of this authorization.

Financial Responsibility

I understand that I remain financially responsible for all services provided to my child, including any balance not covered by insurance.

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Duration of Authorization

This authorization becomes effective on the date signed below.
This authorization will remain in effect until the earliest of:
☐ One (1) year from the signature date

OR

Expiration Date: _____ /_____ /_____

This authorization may be revoked at any time by submitting written notice to Quad Cities Pediatrics or Just 4 Kids Urgent Care. Revocation will not affect treatment already provided before the revocation is received.

Parent/Guardian Certification
I certify that:

- I am the child's legal parent or legal guardian.
- I have legal authority to consent to medical treatment.
- The information provided on this form is true and correct.
- I understand the nature and purpose of this authorization.

Parent/Guardian Signature:

_____

Printed Name:

_____

Date:

_____ /_____ /_____

Office Use Only

Identity of Parent/Guardian Verified By:

_____

Relationship Verified:
☐ Yes

Date Received:
_____ /_____ /_____

Staff Initials: _____

Practice Policy

The provider reserves the right to contact the parent or legal guardian before treatment if additional information or consent is necessary, or to postpone non-emergent treatment until appropriate consent is obtained.