Patient Name: _____ Date of Birth: _____CAP Account # _____

Capital Area Pediatrics
your neighborhood pediatrician

MEDICAL AUTHORIZATION FOR ALTERNATE CAREGIVER (ACG)

Permission for medical treatment:

In my absence, I _____ *(name of parent or legal guardian)* authorize

_____ (*name of authorized adult) as my child's "Alternate Care Giver*" (ACG) to seek and authorize treatment for my child (listed above) from Capital Area Pediatrics, Inc. for the following types of service (check all that apply):

- ☐ Urgent Sick Care (may include laboratory testing or injection of medication)
- ☐ Emergency Care (may include hospitalization, and items designated above)
- ☐ Office Surgery (i.e. wart removal, incision and drainage, wound repair and local anesthesia)
- ☐ Preventive Care and Immunizations

This authorization is effective as of: _____ and will expire on _____, unless I withdraw authorization with written notice prior to expiration date.

ACG must have a picture ID that matches the following:

ID Description: _____ (i.e. VA driver's license) ID Number: _____

ACG relationship to Child: _____ (stepparent, nanny, grandparent)

- I understand that a parent/guardian is required to attend the first visit with the child.
- I understand that if the provider feels this non-parent/guardian does not supply sufficient information during a visit, the provider may discontinue the visit, and reschedule the appointment when a parent/guardian is able to attend.

Parent/Guardian Contact Information (in case the provider needs to speak directly with you)

Parent /Guardian (a): Name_____ Daytime phone: _____

Parent/Guardian (b): Name_____ Daytime phone: _____

Parent or Legal Guardian's Signature: _____**Date:** _____