



**Authorization for Treatment of a Minor  
8 Regional Circle  
Pinehurst, NC 28374**

Date: \_\_\_\_\_

I, \_\_\_\_\_ give \_\_\_\_\_,

relationship: \_\_\_\_\_ permission to authorize

medical treatment for my child \_\_\_\_\_ which may include

immunizations, office visit, or any other services needed. I understand that no immunizations or injections will be given without parent present.

This authorization will have to be updated yearly.

I may rescind this authorization at any time either orally or written.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date