



Little Traverse Primary Care

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AUTHORIZATION FOR EXAMINATION/TREATMENT OF A MINOR

Important: All blanks MUST be filled in

Patient: _____

Birthdate: _____

I _____ give Little Traverse Primary Care and its associates
(please print name of parent giving permission)

Permission to evaluate my minor child _____,

from this _____ day of _____ year _____ in their office.

This form is only good for one time use. Please be aware.

I authorize Little Traverse Primary Care and its associates to:

(check one option only)

_____ Evaluate (only perform a physical examination pertaining to the problem at hand)

_____ Evaluate **and** treat the current condition(s), including the performance of the following procedures/tests/labs (check applicable):

_____ X-rays

_____ Injections (i.e. antibiotics and steroids)

_____ Immunizations (as needed and directed by the Michigan's state recommendations)

_____ HPV immunization- Gardasil

_____ Suturing ("stitches")

_____ Casting/splinting

_____ Lesion removal

_____ Foreign body removal

_____ Nebulizer treatments

_____ Prescribe and/or refill medications

_____ Give samples of prescribed medication (if applicable/available)

_____ EKG (electrocardiogram) or PFTs (pulmonary function studies)

_____ Holter monitor or blood pressure monitor

_____ Urine pregnancy test (Will be automatically done if child is a female between the ages of 12 and 17 and an xray is needed)

_____ Labs (blood, urine, throat swab, nasal swab,etc.)

- If the patient is under 18 years of age, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship:

Parent

Legal Guardian

Signature: _____

Date: _____