AUTHORIZATION FOR EXAMINATION/TREATMENT OF A MINOR

Important: All blanks MUST be filled in

Single Visit Form

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.

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:** _____

8881 M-119 Harbor Springs, MI 49740 Phone: 231-347-5400 Fax: 231-348-2515