



Care of a Minor Child Waiver

I, _____ being the parent or legal guardian of _____ authorize _____ to bring my child in to see their provider at New West Physicians. By signing below I authorize the aforementioned person to make any medically relevant decisions regarding my minor child. This includes any decisions regarding medications, blood work, imaging, and any other decision involved in my child's care.

Signature

Date

Print Name

Child's date of birth