3401 Minnesota Drive Suite 100
Anchorage, AK 99503
P: (907) 677-9200
F: (855) 652-6201

ANCHORAGE MEDICAL SERVICES (AMS URGENT CARE)
Consent to Treat a Minor Without Parent or Legal Guardian Present

Full Name of Minor: _____ Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Parent/Guardian: _____ Relationship to Minor: _____

Phone Number: _____ Alternate Phone: _____

Authorized Consent

I, the undersigned, am the parent or legal guardian of the minor listed above. I hereby authorize Anchorage Medical Services (AMS Urgent Care) and its medical providers to evaluate and provide medical care, including diagnosis, treatment, and procedures, deemed medically necessary for the above-named minor.

I understand that this consent applies when I am not physically present at the time care is provided. I give permission for my child to receive medical care, including but not limited to:

- Evaluation and treatment of illness or minor injuries
- Physical exams
- Diagnostic testing (e.g., labs, imaging)
- Administration of over-the-counter or prescription medications as deemed necessary by the provider

Optional: Additional Individuals Authorized to Accompany Minor

The following individuals may accompany my child and are authorized to make medical decisions in my absence:

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Consent Duration

This authorization is valid:

☐ For this visit only
☐ For all visits between ____ / ____ / _____ and ____ / ____ / _____
☐ Until revoked in writing

Parent/Guardian Signature: _____ Date: ____ / ____ / _____