

IF YOUR CHILD NEEDS MEDICAL, DENTAL, HEALTH OR HOPITAL SERVICES, YOU AS A PARENT MUST GIVE PERMISSION. **IT'S THE LAW.**

A CHILD MAY BE TREATED WITHOUT PARENTAL CONSENT WHEN A PHYSICIAN DETERMINES A TRUE EMERGENCY EXISTS. THAT MEANS THE DOCTOR DETERMINES THE CHILDS NEEDS IMMEDIATE MEDICAL CARE AND THAT AN ATTEMPT TO OBTAIN PARENTAL CONSENT WOULD RERSULT IN A DELAY WHICH WOULD INCREASE THE RISK TO THE CHILDS LIFE OR HEALTH.

EXCEPT IN A TRUE EMERGENCY, CARE MAY BE ORDINARILY RENDERED TO A CHILD ONLY WITH THE CONSENT OF THE PARENT OR LEGAL GARDIUAN. SOMETIMES A CHILD MAY NEED UNEXPECTED CARE WHICH IS NOT, HOWEVER, A TRUE EMERGENCY. IN SUCH CASES, MAKING AN EFFORT TO CONTACT A PARENT FOR PERMISSION CAN DELAY TREATMENT AND CREATE UNNECESSARY ANXIOUS MOMENTS FOR THE CHILD.

THIS IS A LEGAL DOCUMENT. WITH IT YOU MAY APPOINT RELATIVES, FRIENDS, TEACHERS, CLERGY, NEIGHBORS – ANYONE WHO IS OVER 18 YEARS OF AGE – TO BE RESPONSIBLE FOR YOUR CHILDREN WHEN YOU ARE AWAY FROM THEM. IT IS ESPECIALLY IMPORTANT TO PREPARE THIS FORM FOR THE OCCASIONS WHEN YOU KNOW IT WILL BE HARD TO CONTACT YOU.

FILL OUT THIS FORM CAREFULLY. HAVE YOUR SIGNATURE WITNESSED BY AN ADULT DIFFERENT FROM THE PERSON YOU ARE MAKING RESPONSIBLE FOR YOUR CHILD(REN).

AUTHORIZATION

 for medical treatment of minors 

NAMES OF MINORS	BIRTHDATES	IDENTIFY ALLERGIES OR SPECIAL CONDITIONS

I/WE, BEING THE PARENT(S) OR LEGAL GUARDIANS(S) OF THE ABOVE-NAMED MINOR(S), DO HEREBY APPONIT:

NAME	ADDRESS	PHONE

TO ACT IN MY/OUR BEHALF IN AUTHORIZING UNEXPECTED MEDICAL, DENTAL, SURGICAL CARE AND HOSPITALIZATION FOR THE ABOVE-NAMED MINOR(S) DURING THE PERIOD OF MY/OUR ABSENCE, FROM:

MONTH	DAY	YEAR	UNTIL	MONTH	DAY	YEAR

THIS DOCUMENT SHALL BE PRESENTED TO A PHYSICIAN, DENTIST OR APPROPRIATE HOSPITAL REPRESENTATIVE AT SUCH TIME AS UNEXPECTED MEDICAL, DENTAL, SURGICAL CARE OR HOSPITALIZATION MAY BE REQUIRED

PARENT/GUARDIAN		PARENT/GUARDIAN	
SIGNATURE		SIGNATURE	
ADDRESS	DATE	ADDRESS	DATE
WITNESS		WITNESS	
SIGNATURE		SIGNATURE	
ADDRESS	DATE	ADDRESS	DATE

HOSPITALIZATION COVERAGE FOR ABOVE-NAMED MINOR(S):

INSURANCE	INSURANCEID

FAMILY PHYSICIANS:

NAME/PHONE NUMBER	NAME/PHONE NUMBER