Authorization to Consent to Medical or Surgical Treatment of a Minor

I (We), the undersigned parent(s) or legal guardian(s)

of ..... ,
name

date of birth ..... ,

do hereby authorize ..... ,
name

( ) ..... ,
phone

..... ,
address

to consent on my (our) behalf to any medical treatment, hospitalization or surgery for said child, if I (we) the parent(s) or legal guardian(s) cannot be reached.

It is understood that this authorization is given in advance of any specific hospitalization, medical treatment or specific consent on my (our) behalf and any treatments or attention given under the exercise of the authorized be in the best judgement deemed necessary.

I (We) will be responsible for charges resulting from any medical treatment, surgery or hospitalization rendered under this authorization.

WHO TO CALL IN AN EMERGENCY

List two people to contact in case of an emergency:

1. .....
name and relationship to family

.....
phone and address

2. .....
name and relationship to family

.....
phone and address

MY CHILD'S DOCTOR IS:

....
name *phone*

.....
address

THE HOSPITAL/MEDICAL CENTER I (WE) PREFER IS:

....
name *phone*

.....
address

DURING OUR ABSENCE, I (WE) MAY BE REACHED AT:

.....
name

.....
phone

EOE

This consent shall remain in effect during the dates

of ..... to ..... unless cancelled in writing by the undersigned before that date.

Signed this ..... day of

....., 20.....

.....
parent/guardian signature

.....
witness signature

MEDICAL INFORMATION

List any restrictions for medical/surgical treatment:

.....

Date of last tetanus: .....

Allergies to food or drugs: .....

Medications child is currently taking: .....

.....

List any special medical problems or conditions:

.....

CHILD'S DENTIST

.....
name

.....
phone

.....
address

INSURANCE INFORMATION

Policy holder's name. .....
(Please include a copy of your insurance card)

Policy holder's employer. .....
name

.....
phone

.....
address

Relationship to patient .....

Policy number .....

Group number .....

Dignity Health.