

Consent for Medical Treatment of a Minor Child

MidMichigan Health

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This is a legal document. Give it to a physician, dentist or hospital representative when medical, dental, surgical care or hospitalization is required and the child's parents cannot be reached for permission.

I (We) _____ and _____
(name) (name)

do hereby state that I am (we are) the parent(s) or legal guardian(s) of:

_____, a minor, age _____, born _____ / _____ / _____
(name) (date of birth)

who resides with me (us) at _____
(address)

in _____, _____, _____
(city) (county) (state)

I (We) authorize _____, an adult, who resides at
(name)

_____ in _____, _____, _____
(address) (city) (county) (state)

to act in my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minor(s)

during the period(s) of my/our absence from: _____ / _____ / _____ through _____ / _____ / _____
(month, day, year) (month, day, year)

In no event shall this delegation of parental rights be effective for more than six months. _____ / _____ / _____
(date signed)

(signature of parent or guardian) (signature of parent or guardian)

Allergies: _____

Chronic diseases or medical problems: _____

Medicines child is now taking: _____

Family Physician: _____ Telephone: _____

Medical Insurance Carrier or Government Program: _____

ID Number: _____ Member's Name: _____

Benefit Code: _____ Account Number: _____

Parent/Legal Guardian Contact Phone Number(s): _____

