Consent For Medical Treatment Of a Minor Child

________________________________
Family Physician

________________________________
Telephone

________________________________
Medical Insurance Carrier or Government Program

________________________________
ID Number

________________________________
Member’s Name

________________________________
Benefit Code

________________________________
Account Number

Parents may be reached as follows:

________________________________
________________________________
________________________________

This is a legal document. Take it with you and give it to the physician, dentist or hospital representative so that necessary treatment can be given to a child whose parents cannot be contacted for permission.
I, (We) _________________________________ and __________________________________________

(name) (name)
of ____________________, ___________________, ____________________, do hereby state that
(city) (county) (state)
I am (we are) the parent(s) or legal guardian(s) of:
________________________________________, a minor, age _______, born ________________
(name) (date)
who resides with me (us) at _________________________________________________________
(address)
I (We) authorize __________________________________________________________, an adult,
(name)
who resides at __________________________________________________________________
(address)
in ____________________, ____________________, _________________________
(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)

Signature of parent or guardian Signature of parent or guardian

This document shall be presented to a physician, dentist or appropriate hospital representative at such time
as medical, dental, surgical care or hospitalization may be required.

Allergies: _____________________________________________________________________
Chronic diseases or medical problems: __________________________________________________
___________________________________________________________________________
Medicines child is now taking: ________________________________________________________
___________________________________________________________________________
___________________________________________________________________________