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INSTRUCTIONS TO PARENTS FOR CONSENT FOR MINOR'S MEDICAL TREATMENT

Purpose: This form enables you to designate another person who will have the authority to consent to emergency medical treatment for your child if you are unavailable. You should fill out and sign one form for each child every time that you will be temporarily unavailable to consent to medical treatment on behalf of your child. This form is typically used when you go on vacation without your child, but can also be used to give consent to a caregiver who supervises your child on an ongoing basis.

Pages 1-3: Fill out as much or as little information about the child as you wish. These pages have no legal effect, but will provide helpful information to your child's temporary caregiver and medical personnel.

Page 4: Add the name of the person that you are designating and the dates for which the designation will be effective. Both parents/guardians should sign in the presence of a witness. The same person can witness both signatures.

AUTHORIZATION FOR MEDICAL TREATMENT OF

I. Child's Personal Information

Name:

Date of birth:

Social security #:

Address:

Approximate weight:

II. Child's Insurance Information

A. Primary health care plan:

Policy #:

Telephone #

Policy holder:

Policy holder's date of birth:

Relationship of policy holder to child:

B. Other Medical insurance:

Policy #:

Telephone #

Policy holder:

III. Child's Medical Providers

A. Primary care physician:

Address:

Telephone #:

B. Dentist:

Address:

Telephone #:

C. Specialist #1:

Area of practice:

Address:

Telephone #:

D. Specialist #2:
Area of practice:
Address:
Telephone #

E. Closest hospital:
Address:
Telephone #:
Directions:

IV. Child's Medical Condition

A. Child's current prescription medication #1:
Reason for taking this medication:
Dosage instructions:
Location of medication:

B. Child's current prescription medication #2:
Reason for taking this medication:
Dosage instructions:
Location of medication:

C. Over-the-counter treatments:

1. Fever/headache:
Medication:
Dosage:
Location of medication:
2. Cold symptoms:
Medication:
Dosage:
Location of medication:
3. Upset Stomach:
Medication:
Dosage:
Location of medication:

- 4. Other symptoms:
Medication:
Dosage:
Location of medication:

- D. Child's allergies to:
Food:
Medications:
Other:
What type of reaction is possible?

What should be done if child is exposed?

Location of medication for treatment:

- E. Other important medical information:

V. Contact Information

- A. Name of Mother or Legal Guardian #1:
Address if different from child:
Home telephone #:
Office telephone #:
Cellular telephone #:
Temporary contact information:

- B. Name of Father or Legal Guardian #2:
Address if different from child:
Home telephone #:
Office telephone #:
Cellular telephone #:
Temporary contact information:

- C. Other adult to notify if the parents/guardians cannot be reached:
Relationship to child:
Address:
Home telephone #:
Office telephone #:
Cellular telephone #:

VI. Authorization and Consent of Parents or Legal Guardians

I affirm that I have legal custody of the aforementioned minor child (hereinafter "Minor").

I grant my authorization and consent for _____ (hereinafter "Supervising Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor.

In addition, if the injury or illness of the Minor requires treatment by a medical professional, the Supervising Adult is authorized to grant or withhold consent to any medical treatment that is deemed advisable by any physician, surgeon, dentist, hospital, emergency medical personnel or other medical professional or institution licensed to practice in the state where the treatment is to occur. This includes, but is not limited to, consent for any x-ray or other diagnostic tool, anesthetic, blood transfusion, medication, surgery, or other treatment option.

I understand that this consent is given in advance of any medical treatment, but is given to provide the Supervising Adult full authority to exercise his or her best judgment regarding the Minor's medical care based on the advice of a medical professional.

This authorization is effective commencing on _____, 20____, and expiring on _____, 20____.

Signature of Mother
Or Legal Guardian #1

Date

Signature of Witness

Signature of Father
Or Legal Guardian #2

Date

Signature of Witness

Information about witnesses (can be the same witness for both signatures):

Name: _____

Name: _____

Address: _____

Address: _____

Telephone #: _____

Telephone #: _____