AUTHORIZATION FOR MEDICAL TREATMENT OF YOUR CHILDREN

If your child needs emergency treatment or non emergency medical, dental, surgical care or hospital services, you as a parent or legal guardian, must give permission.

In an emergency, your child may be treated without your consent if a physician determines that your child needs immediate medical care and further delay increases the risk to your child's life or health.

In situations that are not emergencies, your child may need unexpected care. In these cases, contacting parents for permission can delay treatment and create unnecessary anxious moments and discomfort for your child.

How can you prepare for the unexpected care your children might need when you are away?

- Make sure the person who is caring for your children knows how to reach you at all times.
- When you know you will be hard to reach, use the form below to give permission to other adults to authorize medical care for your children. They can then act for you and give permission for your child to be treated if unexpected care is needed.
- Fill out this form carefully. With it, you may appoint relatives, friends, teachers, neighbors or anyone you know over 18 years of age to authorize treatment in your absence. For further protection, have the form signed by an adult other than the person you have appointed to authorize medical care for your children.
- After you complete the form, give it to the adults you have designated and explain its use. Make sure they know that they should take the form with them to the physician's or dentist's office or to the hospital.

Name of Minors	Birthdate	Identify allergies or special conditions

I/We, being the parents or legal guardians of the above named minors, do hereby appoint:

Name_____Phone_____

Address_____

Name_____Phone_____

Address_____

To act in my/our behalf in authorizing medical, dental, surgical care and hospitalization for the above named minors during the period of my absence from

Date (month/day/year)_____through date (month/day/year)

In no event shall this delegation of parental rights be effective for more than six months. 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.

Parent/Guardian Signature _____
Address _____
Date _____
Witness Signature _____

Parent/Guardian Signature _____
Address _____
Date _____
Witness Signature _____

Insurance coverage for above named minors:

Insurance Company Name_____ID or Contract Number_____

Appointed Parent/Guardian Representative Signature_____Date_____
Appointed Parent/Guardian Representative Signature_____Date_____

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.