Consent to Treatment of a Minor When Parents/Guardians Are Temporarily Unavailable

The undersigned parent or legal guardian of _____ authorizes the person(s) listed below to
(Child's Name)
consent to treatment of the child, including, but not limited to, emergencies, x-ray, anesthetic, or surgical services when I am not immediately available in person, or by a telephone call to _____.
(Phone Number)
I grant my permission to treat and provide any healthcare services to my child that the provider deems necessary for treatment if my child arrives at the office **UNACCOMPANIED**. (Drives themselves)

_____

Print Name Signature Date

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

1. Person(s) who may consent to treatment (please print):

Name: _____ DOB _____ Relationship to child: _____ Phone: _____

Name: _____ DOB _____ Relationship to child: _____ Phone: _____

Name: _____ DOB _____ Relationship to child: _____ Phone: _____

2. Medical Concerns: _____

3. Known Allergies: _____

Name of Parent or Legal Guardian: _____ Relationship to Child: _____
(Print Name)

Signature: _____ Date: _____

This Consent is effective for one year unless withdrawn in writing by the child's parent or guardian.