TEMPORARY AUTHORIZATION OF CONSENT TO TREAT MINOR CHILDREN

I, _______________________, parent or legal guardian of_______________________, born

the____ day of_________________, 20___ do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of

my child while said child is under the care of ___________________________________of

_______________________, City of____________ State of____________ and I am not reasonably available by telephone to give consent.

This authorization is effective from the___ day of _______________________, 20___to

____day of _______________________, 20__

______________________________________ ___________________
Signature of Parent or Legal Guardian **Date**

______________________________________ ______________________________
Witness Signature Witness Name (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address____

Parent/Guardian Telephone: ____________________ Email: __________________________

Last Tetanus: ____________________ Current Medications: ___________________________

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Allergies to drugs or foods: ____

Special Medications, Blood Type or Pertinent Information: ______________________________

____

Child's Physician: _________________________ Phone: ____________________________

Insurance: _____________________________ Policy #________________ Group#________

Preferred Hospital: ____