Temporary Authorization to Consent to Treat a Child

I (we)_____

Name(s) and address(es) of parents

designate to _____

Name and address of designee

the power to consent in our absence to medical care for our child(ren):

_____ _____

Name(s) and age(s) of child(ren)

_____ _____

Parent(s)' phone number: _____

Child(ren)'s physician(s): _____

Physician's address and phone number: _____

_____

Medical insurance company: _____

Policy #: _____

Dates of expected absence from _____ to _____

CHILD(REN)'S MEDICAL HISTORY

Chronic conditions_____

Medications that need to be given on a regular basis:

_____ _____

Child's Name Medication name, dosage, frequency

_____ _____

Child's Name Medication name, dosage, frequency

_____ _____

Child's Name Medication name, dosage, frequency

Allergies:_____

Dietary or other restrictions: _____

Written by Robert Brayden, MD, Associate Professor of Pediatrics, University of Colorado School of Medicine.

This content is reviewed periodically and is subject to change as new health information becomes available. The

information is intended to inform and educate and is not a replacement for medical evaluation, advice, diagnosis or treatment by a healthcare professional.