

**AUTHORIZATION FOR MEDICAL CARE OF A MINOR CHILD AND DESIGNATION OF
 PERSON AUTHORIZED TO GIVE SUBSTITUTE CONSENT FOR TREATMENT OF A MINOR
 CHILD**

Please print all information

Child Name _____ Birthdate _____

Child Name _____ Birthdate _____

Child Name _____ Birthdate _____

Child Name _____ Birthdate _____

Home Address _____ City, State, Zip _____

Parent(s) or Legal Guardian(s) Name(s) _____

Caregiver _____ Phone Number _____

(Name and Relationship)

The above named caregiver shall be authorized to consent for all medical and/or surgical treatment and/or other medical procedures (including administration of anesthesia, blood transfusions, diagnostic tests, etc), for the above named child(ren), which may be required during my/our absence. If circumstances permit, I would like to have our doctor consulted in connection with such treatment. Please attempt to contact me/us at the following telephone number: _____

Child's Physician _____ Phone Number _____

I agree to pay for all services provided to my child(ren) in my absence. I have provided a copy of my insurance card with this authorization.

This authorization shall be in effect from: _____ through _____

(Month/day/year)

(Month/day/year)

(Signature of parent or legal guardian)

(Date)

(Signature of parent or legal guardian)

(Date)

County of _____

State of _____

Subscribed and sworn to before me this _____ day of _____, 20____.

(Notary Public)

Notary stamp

<p><i>This consent form should accompany the child to the hospital or physician's office at the time the child is taken for treatment.</i></p>
